

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15737

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15752

## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>DONALD EUGENE BARNES</b>			2a. DATE OF DEATH Nov. Month 25 Day 1968			2b. HOUR 9:30 P.M.					
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>OCT. 16, 1923</b>		6. AGE (In years last birthday) <b>45</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL CO.</b> Md.					
10. CITY OR TOWN OF DEATH <b>WESTMINSTER</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>CARROLL CO. GEN. HOSP.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>MECHANIC, RUG MILL</b>			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>CARROLL</b>		13c. CITY OR TOWN <b>WESTMINSTER</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET AND NUMBER <b>42 LIBERTY ST.</b>			
14. FATHER'S NAME First Middle Last <b>CURTIS E. BARNES</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>NELLIE ECKER</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>YES</b>			16b. SOCIAL SECURITY NO. <b>217-18-7992</b>		17. INFORMANT <b>MRS. JUDITH P. BARNES</b>			Address <b>SAME ADDRESS</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>4339</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 hours</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>332 X</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 25, 1968</b> , to <b>Nov 25, 1968</b> , that (I) (we) last saw the deceased alive on <b>Nov 25, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>John S. Harshey, M.D.</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <b>11/25/68</b>					
22d. PHYSICIAN'S NAME (Type) <b>JOHN S. HARSHEY, M.D.</b>						22e. ADDRESS <b>8 Danahoe St. Westminster, Md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>11/29/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PIPE CREEK CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>RURAL NEW WINDSOR, MD</b>					
24. FUNERAL DIRECTOR <b>J.S. Myers, Jr. Westminster, MD</b> ADDRESS						25a. REC'D BY REGISTRAR <b>DEC 2 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

100000

1975

HOWARD EUGENE BARNES

MALE WHITE

11/11/1923

Marshall W.D.

General Co.

WESTMINSTER MARSHALL BARNES

HOWARD EUGENE BARNES

CURTIS E. BARNES

11-18-1923 MARSHALL BARNES



11/11/23 11/11/23 11/11/23

11/11/23 11/11/23 11/11/23

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15738

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

15753

1. DECEASED-NAME (Type or print) <u>Flossie Albertha Bell</u>			2a. DATE OF DEATH Nov Month 13 Day 1968 Year			2b. HOUR 8:55 PM			
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>Sept 3-1885</u>		6. AGE (In years lost birthday) <u>83</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <u>Fredrick Co Md</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Carroll</u> Md.			
10. CITY OR TOWN OF DEATH <u>Westminster</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>127 Egleston St Westminster Md</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Housework</u>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>Carroll</u>		13c. CITY OR TOWN <u>Westminster</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>104 Anchor St</u>	
14. FATHER'S NAME First Middle Last <u>George A. Bell</u>			15. MOTHER'S MAIDEN NAME First Middle Last <u>Ida Virginia Harbaugh</u>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <u>No</u>		16b. SOCIAL SECURITY NO. <u>215-54-4217</u>		17. INFORMANT <u>Mrs Stewart Bell</u>		Address <u>104 Anchor St Westminster Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>4129</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>5 yrs</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4200</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>68</u> , to <u>Nov 13</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11-3</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>W N Foward M.D.</u> DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>11-17-68</u>			
22d. PHYSICIAN'S NAME (Type) <u>W H Foward M.P.</u>				22e. ADDRESS <u>25 N. Main St Manchester Md 21102</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>11/16/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>KRIDERS CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>WESTMINSTER CARROLL MD</u>			
24. FUNERAL DIRECTOR <u>J. E. Myers, Jr. Westminster, Md.</u>				25a. REC'D BY REGISTRAR <u>NOV 18 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be recorded within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
15739  
CERTIFICATE OF DEATH

15754

1. DECEASED-NAME (Type or print) <b>MARY MISSOURI BENEDICT</b>			2a. DATE OF DEATH Month <b>11</b> Day <b>17</b> Year <b>68</b>			2b. HOUR <b>3:00 PM</b>					
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>FEB 14 - 1884</b>		6. AGE (In years last birthday) <b>84</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL</b> Md.					
10. CITY OR TOWN OF DEATH <b>NEW WINDSOR</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>NONE</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEKEEPER</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>			13b. COUNTY <b>CARROLL</b>			13c. CITY OR TOWN <b>NEW WINDSOR</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>NONE</b>	
14. FATHER'S NAME First <b>WILLIAM</b> Middle <b>LOVELL</b> Last <b>LOVELL</b>			15. MOTHER'S MAIDEN NAME First <b>IDA</b> Middle <b>SLOVAKER</b> Last <b>SLOVAKER</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>219-05-9883</b>			17. INFORMANT Address <b>PEARL COE NEW WINDSOR MD</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic CVD</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4221</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>4/30/68</b> to <b>11/17/68</b> , that (I) (we) last saw the deceased alive on <b>11/16/68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>M. E. Robertson MD</b> DEGREE 22d. PHYSICIAN'S NAME (Type) <b>M E ROBERTSON</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>11/17/68</b>			
22e. ADDRESS <b>New Windsor, Md</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>NOV 20 - 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WINTERS</b>			23d. LOCATION (City or Town) (County) (State) <b>NEW WINDSOR RURAL MD</b>			
24. FUNERAL DIRECTOR <b>D D Hartzler &amp; Sons New Windsor</b> ADDRESS						25a. REC'D BY REGISTRAR DATE <b>NOV 20 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Richard Judge</b>			

CERTIFICATE OF NATURALIZATION



UNITED STATES DEPARTMENT OF JUSTICE  
BUREAU OF THE CENSUS  
WASHINGTON, D.C. 20540



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in, and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15740		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		15755	
CERTIFICATE OF DEATH					
1. DECEASED-NAME (Type or print) First Middle Last <b>LAURA CATHERINE Bollinger</b>			2a. DATE OF DEATH Month <b>Nov</b> Day <b>13</b> Year <b>1968</b>		2b. HOUR <b>8:30 P.M.</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>		5. DATE OF BIRTH <b>Oct 29 1883</b>		6. AGE (In years last birthday) <b>85</b> YRS.
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b>
10. CITY OR TOWN OF DEATH <b>MANCHESTER</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>409 York Street Manchester Md</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>House wife</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Carroll</b>	13c. CITY OR TOWN <b>Manchester</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>409 York Street</b>
14. FATHER'S NAME First Middle Last <b>HENRY K. Miller</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Missouri E. Miller</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-32-6907</b>		17. INFORMANT Address <b>Calvin H Miller Manchester Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4129 Acute Gastric Hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>4221</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Suddenly</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Cordis Cerebri Disease</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 1</b> , 19 <b>60</b> , to <b>Nov 13</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Nov 13</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Joseph E. Bush</b>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>11-13-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Joseph E. Bush MD</b>		22e. ADDRESS <b>HAMPSTEAD Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Nov. 16, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Immanuel Cemetery</b>	
23d. LOCATION (City or Town) (County) (State) <b>Manchester, Md.</b>		24. FUNERAL DIRECTOR ADDRESS <b>Tipton - Eline Funeral Home Hampstead, Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 18 1968</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

14135

RECEIVED

14135



14135





MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15741

15756

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1-13. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		Month		Day		Year		2b. HOUR	
BEVERLY JEAN BURDEN								11-15-68		11		15		1968		3:00 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		Month		Day		Year	
female	white	4-21-51		17 YRS		MONTHS		DAYS		11		15		1968		3:25 P.M.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH									
New Mexico		U.S.A.		WIDOWED		DIVORCED		Carroll									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY											
Sykesville		Springfield State Hospital		Student		School											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER									
Md.		Carroll		Westminster		YES		NO		Route #3							
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last			
unknown								unknown									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
no		none		Springfield State Hosp. Records													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
957X		Fractured skull						Sudden									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		978X		(b)		DUE TO, OR AS A CONSEQUENCE OF											
				(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		Psychoneurotic reaction, other, (with hysterical features).															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES		NO									
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		5-2 B											
3:00 P.M. 11-15-68				Jumped off fire escape													
21d. INJURY OCCURRED WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State							
NOT WHILE AT WORK		Nichols Building		Springfield		Sykesville		Carroll		Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner							
ACTUAL SIGNATURE		W. Glenn Speicher, M.D.		CHIEF MEDICAL EXAMINER		ASSISTANT MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		22b. DATE SIGNED		11-15-68					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)							
Burial		11/19/68		Kirkridge Presbyterian		Manchester		Carroll		Maryland							
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
John E. Goff		NOV 20 1968		Charles J. Jager													
John E. Goff Funeral Home		Hampstead, Maryland															

10750

RECEIVED IN THE OFFICE OF THE  
DIRECTOR GENERAL OF THE  
REVENUE DEPARTMENT

FOR THE  
REVENUE DEPARTMENT

REVENUE DEPARTMENT

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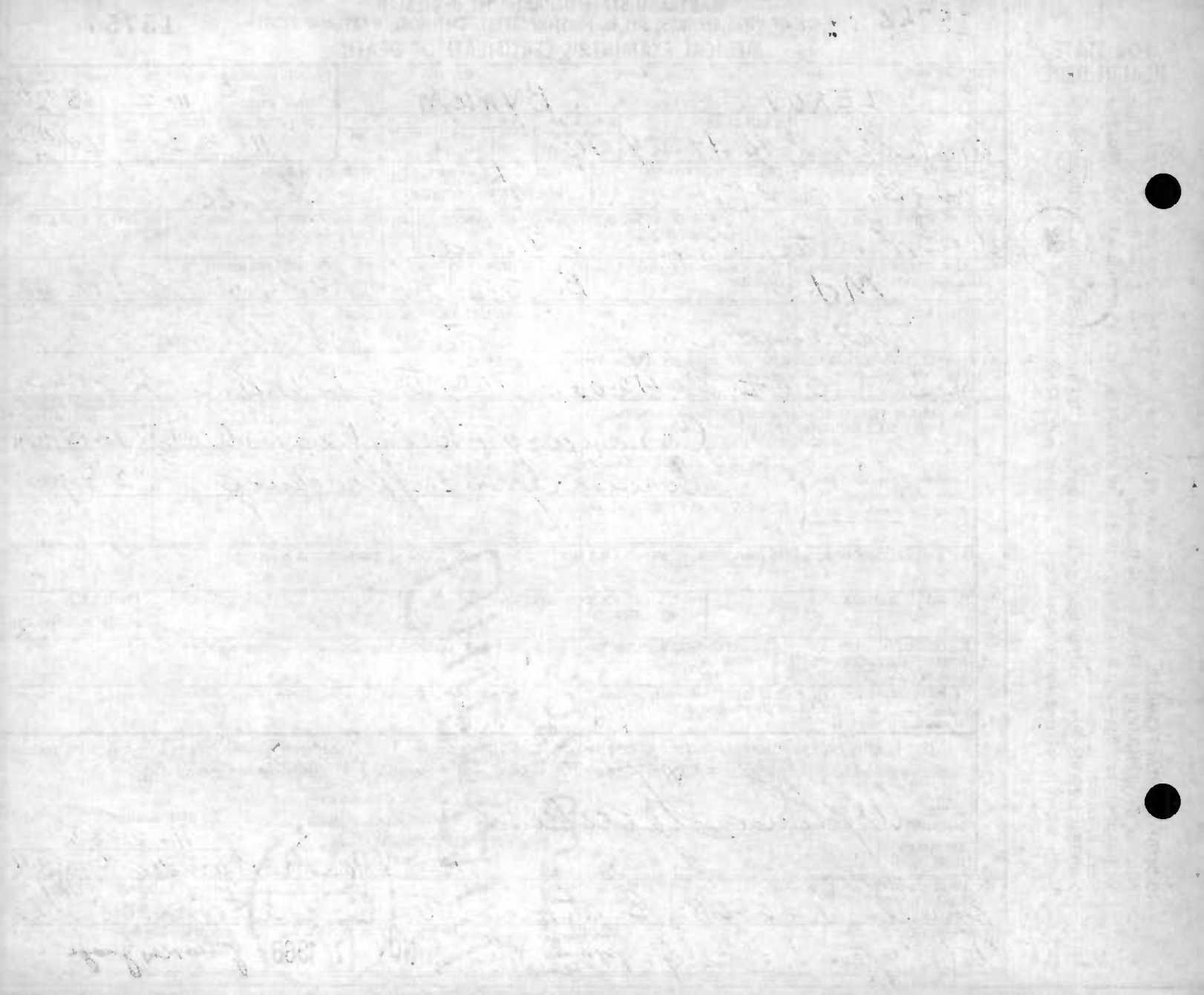
REVENUE DEPARTMENT

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15748 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										15757	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
LEROY			BYNUM			Mated <input type="checkbox"/> 11-2-68			9:45 AM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Male	Colored	4-19-24	44 YRS	MONTHS DAYS		HOURS MIN.		Month 11 Day 2 Year 1968		11:20 AM	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.		
A.C.		USA.				Carroll					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Westminister			Carroll Cos. General								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md						Baltimore				3845 Forest Ave	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Unknown			Estelle Williams								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
Yes			WW# 20719-0021			Montrey Bynum			Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) 4109 Coronary Thrombosis (acute)										10-15 Min	
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Insufficiency										2 1/2 yrs	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
4201											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. P.M. 19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			ASSISTANT MEDICAL EXAMINER			22b. DATE SIGNED		
EXAMINER'S NAME (Type)			M.D.			DEPUTY MEDICAL EXAMINER			11-2-68		
Arlington S. Phillips						155 E. Main St. Westminister Carroll					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County)		23e. REC'D BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
Burial		11-6-68		Baltimore National		Baltimore Md.		NOV 7 1968		Charles Judge	
24. FUNERAL DIRECTOR ADDRESS											
Arlington S. Phillips 1727 N. Mount											



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15748 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Item #6, Film 406 11/20/68 km											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last						2a. DATE OF DEATH Month Day Year			2b. HOUR		
Gertie Calp						Nov. 7 1968			6:45AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Female		White		May 24, 1904		64 63 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.		
Md.		U. S.				Carroll					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Manchester		Longview Nursing Home		Sewing Factory							
13a. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) STATE		13b. CITY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Md.		Carroll		Greenmount							
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last							
Elmer Shaffer				Alberta Cole							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
No		219-01-2427		Mrs James Cheshire		Manchester, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Recurrent congestive heart failure								2 years			
DUE TO, OR AS A CONSEQUENCE OF (b) Rheumatic Heart Disease								30 years			
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
Circosis of Liver (due to E.C.C.)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 12-5, 1959, to 11-7, 1968, that (I) (we) last saw the deceased alive on 4-6, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
M. C. Porterfield		11-8-68		M. C. Porterfield, M.D.		Hampstead, Md.					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		Nov. 9, 1968		Greenmount Cemetery		Greenmount Carroll CO. Md.					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Tipton - Eline Funeral Home Hampstead, Md.		21074		NOV 13 1968		J Charles Judge					



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15744

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15759

# CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last <b>Jean Patterson Carnahan</b>			2a. DATE OF DEATH 11 Month 1 Day 68 Year		2b. HOUR 11 AM
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>6-15-84</b>		6. AGE (In years last birthday) <b>84</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Scotland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Carroll County</b> Md.		
10. CITY OR TOWN OF DEATH <b>Sykesville, Md.</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield State Hosp.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Teacher</b>	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>	13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Silver Spring</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>704 Forest Glen Road</b>	
14. FATHER'S NAME First Middle Last <b>Alexander Carnahan</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Grane McWhirr</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>213-48-3778</b>	17. INFORMANT <b>Medical Record</b> Address <b>Springfield Hospital, Sykesville, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobular Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic Brain Syndrome, associated with senile brain disease.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4129</b> days <b>4300</b> years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)					
<b>Chronic Brain Syndrome, associated with senile brain disease.</b>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (X) (this hospital) attended the deceased from <b>8-13</b> , 19 <b>68</b> , to <b>11-1</b> , 19 <b>68</b> , that (X) (we) last saw the deceased alive on <b>11-1</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Renato R. Espina, MD</b>			DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <b>11-1-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>RENATO R. ESPINA, MD</b>			22e. ADDRESS <b>Springfield State Hospital Sykesville, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE <b>11-4-68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>J. Wm Lees Crematory</b>	23d. LOCATION (City or Town) (County) (State) <b>Washington D.C.</b>		
24. FUNERAL DIRECTOR <b>Harry W. Haight Sykesville, Md.</b>			25a. REC'D BY REGISTRAR DATE <b>NOV 6 1968</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div>15745</div> <div>Item 13 e Film G 407 12/6/68 11w</div> <div>CERTIFICATE OF DEATH</div> <div>15760</div>									
1. DECEASED NAME (Type or print) First Middle Last JAMES THOMAS COATES					2a. DATE OF DEATH Month Day Year 11 23 68			2b. HOUR A.M. or P.M. 5:15 M.	
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH 06-25-1894		6. AGE (In years last birthday) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.			
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hosp				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) unk		12b. KIND OF BUSINESS OR INDUSTRY unk	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montg.		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RFD 2 Rockville, Md 20850	
14. FATHER'S NAME First Middle Last James Coates			15. MOTHER'S MAIDEN NAME First Middle Last Annie Jenkins						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service) unk.		16b. SOCIAL SECURITY NO. 214-54-9300 J		17. INFORMANT Hospital Records		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of prostate</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Convulsive disorder</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days 9 months years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic Brain Syndrome assoc. with convulsive disorder with psychotic react.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <u>74</u> (this hospital) attended the deceased from <u>Nov. 19</u> , 19 <u>68</u> , to <u>Nov. 23</u> , 19 <u>68</u> , that <u>1</u> (we) last saw the deceased alive on <u>Nov. 23</u> , 19 <u>68</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above <u>74</u> (we) <u>did</u> (did not) view the body after death.									
22b. SIGNATURE <u>Suha Ozgun.</u>					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 11/23/68		
22d. PHYSICIAN'S NAME (Type) Suha Ozgun, M. D.					22e. ADDRESS Springfield State Hosp., Sykes., Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>11-28-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Lukes Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Sykesville</u> <u>MD</u>			
24. FUNERAL DIRECTOR <u>Harry W. Noyt</u>		ADDRESS <u>Sykesville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 2</u> 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>William Albert Deitz</b>			2a. DATE OF DEATH Month <b>Nov</b> Day <b>25</b> Year <b>1968</b>		2b. HOUR <b>3:35</b> M
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>Sept 27 - 1897</b>		6. AGE (In years last birthday) <b>71</b> YRS.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Baltimore</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Carroll</b> Md		
10. CITY OR TOWN OF DEATH <b>Manchester</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Longview Nursing Home 128 N Main</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Bus Driver</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore Transit</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>	13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Upperco</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER	
14. FATHER'S NAME First <b>John</b> Middle <b>Edward</b> Last <b>Deitz</b>	15. MOTHER'S MAIDEN NAME First <b>E</b> Middle <b>Myers</b> Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16b. SOCIAL SECURITY NO. <b>215-09-3654</b>	17. INFORMANT <b>Mrs Wm Deitz</b> Address <b>Rustertown, Md</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Generalized Arteriosclerosis 5 yrs</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>5 yrs</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 Months</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>331X Arteriosclerotic Cardiovascular Disease</b>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>10/11</b> , 19 <b>68</b> , to <b>10/25</b> , 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>11/25</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>W H Foard MD</b>		22c. DATE SIGNED <b>11-25-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>W. H Foard</b>		22e. ADDRESS <b>25 N. Main St Manchester, Md 21102</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Nov. 29, 1968</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Upperco, Md.</b>		
24. FUNERAL DIRECTOR <b>Tipton - Eline Funeral Home Hampstead, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 2 1968</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15747										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										15762																																							
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
MARIE (NMN) DUBOW										NOVEMBER 5, 1968										7:30 PM																																							
3. SEX Female										4. RACE White										5. DATE OF BIRTH										6. AGE (In years last birthday) 72 YRS.										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN									
7a. BIRTHPLACE (State or foreign country) RUSSIA										7b. CITIZEN OF WHAT COUNTRY? (Naturalized) U.S.A.										B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Carroll Md																													
10. CITY OR TOWN OF DEATH Sykesville										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife										12b. KIND OF BUSINESS OR INDUSTRY AT HOME																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland										13b. COUNTY Baltimore										13c. CITY OR TOWN Baltimore										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER 5446 JONQUILL AVE.																			
14. FATHER'S NAME First Middle Last Jacob Mashkes										15. MOTHER'S MAIDEN NAME First Middle Last Ida Aronson																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No										16b. SOCIAL SECURITY NO. 212-05-6180-A										17. INFORMANT MR. MORRIS DUBOW 5446 JONQUILL AVE																																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 485x Bilateral bronchopneumonia										DUE TO, OR AS A CONSEQUENCE OF (b)										DUE TO, OR AS A CONSEQUENCE OF (c)																																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 491x																																																											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) CBS assoc. with senile brain disease, with psychotic reaction																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from 4-25-67, 19, to 11-5-68, 19, that (I) (we) last saw the deceased alive on 11-5-68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE Dr. Antonius Glahn										DEGREE										ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>										22c. DATE SIGNED 11-6-68																													
22d. PHYSICIAN'S NAME (Type) Antonius Glahn, M. D.										22e. ADDRESS Springfield State Hospital Sykesville, Maryland 21784																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL										23b. DATE 11-7-68										23c. NAME OF CEMETERY OR CREMATORY WORKMENS CIRLCE										23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND																													
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD										ADDRESS										25a. REC'D BY REGISTRAR NOV 8 1968										25b. REGISTRAR'S SIGNATURE fCharles Judge																													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
15748										
15763										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR		
Edward John Fitzpatrick						November 26, 1968		6:55AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Male		White		7-19-03		65 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH		Md.		
Maryland		U.S.A.				Carroll County,				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
Sykesville		Springfield State Hospital		Unemployed						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland		Balto. City		Baltimore				1615 Park Avenue		
14. FATHER'S NAME			First Middle Last			15. MOTHER'S MAIDEN NAME			First Middle Last	
Edward J. Fitzpatrick						Mabel Corbin				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give year and dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
Yes		WWI		220-03-1086		Records, Springfield State Hospital				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Bilateral bronchopneumonia</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(b) <u>Right ventricular hypertrophy of heart, due to years</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c) <u>Emphysema</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
1) <u>Alcoholism addiction</u> qualifying										
2) <u>Chronic brain syndrome associated with alcohol intoxication without phrase</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>12-11, 1966</u> , to <u>11-26, 1968</u> , that (I) (we) last saw the deceased alive on <u>11-26, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Octavio A. Ruiz M.D.</u>				DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 11-26-68		
22d. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M.D.				22e. ADDRESS Springfield State Hospital						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		11/29/68		Oak Lawn Cemetery		Baltimore, Md.				
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Schimunek Funeral Home, Inc.				2601 E. Madison St.		DATE DEC 2 1968		<u>Charles Judge</u>		

DEPARTMENT OF HEALTH

10-10-35

Name		Address	
John Doe		123 Main St, Baltimore, Md.	
Age		35	
Sex		Male	
Race		White	
Occupation		Teacher	
Date of Birth		10-10-00	
Place of Birth		Baltimore, Md.	
Marital Status		Single	
Education		High School	
Religion		Catholic	
Previous Illnesses		None	
Current Illness		Cold	
Date of Onset		10-05-35	
Duration		5 days	
Symptoms		Runny nose, sore throat	
Treatment		Rest, fluids	
Recovery		Complete	
Remarks		Patient healthy	

11/30/38  
Baltimore, Md.  
10-10-35  
10-10-35

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15749

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)		First RALPH	Middle STEVEN	Lost FRANKLIN	2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 11/ 9 19 68 <input type="checkbox"/> UNK <sup>M</sup>	
3. SEX male	4. RACE white	5. DATE OF BIRTH ?	6. AGE (In years last birthday) 65 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year November 10, 19 68
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.
10. CITY OR TOWN OF DEATH New Windsor		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) R.D. 1		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) farmer		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN New Windsor		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME Daniel		First Middle Lost Edward Franklin		15. MOTHER'S MAIDEN NAME Ella Drach		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16b. SOCIAL SECURITY NO. 212-32-0007		17. INFORMANT Mrs. Alice Franklin		ADDRESS 28 N. Center St. Westminster, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of Back</u> 8239 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 912.1 Pulmonary Emphysema						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. UNK <sup>M</sup> 11/9/19 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) subj. apparently fell off tractor		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) field		21f. LOCATION Street or R.F.D. No. City or Town County State R.D. 1, New Windsor, Carroll, Maryland		
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)		22b. DATE SIGNED 11/11/68
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 11/13/68		23c. NAME OF CEMETERY OR CREMATORY Winter's Cemetery		23d. LOCATION (City or Town) (County) (State) rural New Windsor, Md.
24. FUNERAL DIRECTOR J. Z. Myers Jr., Westminster, Md.				25a. REC'D BY REGISTRAR DATE NOV 14 1968		25b. REGISTRAR'S SIGNATURE Charles Judge

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NOV 14 1968



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1-7-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
15750 - CERTIFICATE OF DEATH 15765									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
THOMAS			(NONE)			FRITZ SR		11 Month 30 Day 1948 6 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
M		W		MARCH 9-1902		46 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		USA				CARROLL Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
LINWOOD		(NONE)			FARMER		FARM		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		CARROLL		LINWOOD				NONE	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
THOMAS			FRITZ			BETSY SHANE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
NO			213-18-9301		MARY B FRITZ LINWOOD MD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic CVD</u> <u>4129</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) <u>4221</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>1955</u> , 19 <u>  </u> , to <u>11/30</u> , 19 <u>48</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>11/26</u> , 19 <u>48</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> <u>(did)</u> <u>(did not)</u> view the body after death.									
22b. SIGNATURE <u>M.E. Robertson MD</u>					22c. DATE SIGNED <u>11/30/48</u>				
22d. PHYSICIAN'S NAME (Type) <u>M E ROBERTSON</u>					22e. ADDRESS <u>New Windsor Md</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
<u>BURIAL</u>		<u>12/3/48</u>		<u>PIPE CREEK</u>		<u>CARROLL CO MD</u>			
24. FUNERAL DIRECTOR <u>DD Hartley &amp; Sons New Windsor</u>					25a. REC'D BY REGISTRAR DATE <u>DEC 3 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

1970

STATE OF NEW YORK

1970

IN SENATE	
JANUARY 1, 1970	
REPORT OF THE	
COMMISSIONER OF THE	
DEPARTMENT OF	
SOCIAL SERVICES	
ON THE	
ADMINISTRATIVE	
FUNCTIONS OF THE	
DEPARTMENT	
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OFFICE OF THE  
COMMISSIONER  
DEPARTMENT OF  
SOCIAL SERVICES  
ALBANY, NEW YORK

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner. Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15751										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										15766											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																															
1. DECEASED-NAME (Type or Print) <b>SOPHIA THERESA GARCIA</b>										2a. DATE KNOWN OF DEATH <input type="checkbox"/> ESTI- MATED <input checked="" type="checkbox"/> <b>11-28</b> 19 <b>68</b>										2b. HOUR <b>12:45</b> M <b>A</b>											
3. SEX <b>FEMALE</b>		4. RACE <b>CAU.</b>		5. DATE OF BIRTH <b>AUG 30 1915</b>		6. AGE (In years last birthday) <b>53</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>		2c. DATE PRONOUNCED DEAD Month <b>11</b> Day <b>28</b> Year <b>1968</b>										2d. HOUR <b>10:45</b> M <b>A</b>									
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH <b>CARROLL COUNTY</b> Md.																			
10. CITY OR TOWN OF DEATH <b>TANEYTOWN MARYLAND</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>LM TANEYTOWN MD.</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>				13b. COUNTY <b>CARROLL</b>				13c. CITY OR TOWN <b>TANEYTOWN</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET AND NUMBER <b>1M TANEYTOWN MD.</b>															
14. FATHER'S NAME First <b>ADAM SEBROWSKI (DECEASED)</b> Middle <b></b> Last <b></b>										15. MOTHER'S MAIDEN NAME First <b>ANNA PIETRAWSKA (DECEASED)</b> Middle <b></b> Last <b></b>																					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>										16b. SOCIAL SECURITY NO. <b></b>										17. INFORMANT ADDRESS <b>CIRILO GARCIA-1M TANEYTOWN MARYLAND</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis (acute)</b> <b>277X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Obesity</b> (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>Years</b>																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>287X</b>																															
19a. DATE OF OPERATION <b></b>										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b></b>										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b></b>					21b. TIME OF INJURY Month, Day, Year <b>19</b> HOUR A.M. <b></b> P.M. <b></b>					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b></b>																					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK <b></b>					21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b></b>					21f. LOCATION Street or R.F.D. No. <b></b> City or Town <b></b> County <b></b> State <b></b>																					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																															
ACTUAL SIGNATURE <b>W. L. Speicher</b> M.D.										CHIEF MEDICAL EXAMINER <input type="checkbox"/>																					
EXAMINER'S NAME (Type) <b></b>										ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>																					
										DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>135 E. Main St. Westminster, Carroll</b>																					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>										23b. DATE <b>12-2-68</b>																					
23c. NAME OF CEMETERY OR CREMATORY <b>HOLY ROSARY CEMETERY</b>										23d. LOCATION (City or Town) (County) (State) <b>DUNDALK MARYLAND</b>																					
24. FUNERAL DIRECTOR <b>JOHN M. WEBER &amp; SONS INC.</b>										ADDRESS <b>401 S. CHESTER</b>																					
										STREET <b>DEC 2 1968</b>																					
										25a. REC'D BY REGISTRAR <b>for Charles Judge</b>																					
										25b. REGISTRAR'S SIGNATURE <b></b>																					

**Figure 1**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by this funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
15758												
15767												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print)			First AUGUSTA			Middle BURNETTA			Last KEYSER GOINES			
2a. DATE OF DEATH			11 Month 11 Day 68 Year			2b. HOUR			4:45 PM			
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH 08-06-88		6. AGE (In years last birthday) 80 00 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll County			Md.			
10. CITY OR TOWN OF DEATH Sykesville, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Domestic		12b. KIND OF BUSINESS OR INDUSTRY						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 220 N. Johnathan St.				
14. FATHER'S NAME			First Truman			Middle -			Last Keyser			
15. MOTHER'S MAIDEN NAME			First Ruie			Middle -			Last -			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, and (known) (If yes give war or dates of service) No.		16b. SOCIAL SECURITY NO. Unknown		17. INFORMANT Medical Record			Address Springfield Hospital, Sykesville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Days</u>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>331X</u>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (X) (this hospital) attended the deceased from <u>11-6</u> , 19 <u>68</u> , to <u>11-11</u> , 19 <u>68</u> , that (X) (we) last saw the deceased alive on <u>11-11</u> , 19 <u>68</u> , and that in <u>1968</u> (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Paul Ensor, M.D.</u>				DEGREE ATTENDING PHYS.		<input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED <u>11/11/68</u>				
22d. PHYSICIAN'S NAME (Type) Paul Ensor, M.D.				22e. ADDRESS Baltimore, Maryland								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Nov 15 1968		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery			23d. LOCATION (City or Town) (County) (State) Hagerstown Wash. Md.					
24. FUNERAL DIRECTOR <u>John R. Watson</u>				ADDRESS Hagerstown Md.		25a. REC'D BY REGISTRAR DATE NOV 14 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
15753										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH Month Day Year	
Henrietta			NMN		GREGG				November 3, 1968	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
female		Negro		3-25-10			58			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			
Georgia		U.S.A.					Carroll			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Sykesville			Springfield State Hosp.			Housewife				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland					Baltimore				3824 Norfolk Avenue	
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME	
Henry Rucker - dec.									Laura Maddox dec.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address				
no			212-18-4511			Springfield State Hosp. Records				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Infected bed sores.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic cardio-vascular disease with</u> peripheral insufficiency.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days weeks yrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>Diabetes mellitus, uncontrolled.</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>7-16-68</u> , 19 <u>  </u> , to <u>11/3/68</u> , 19 <u>  </u> , that (I) (we) lost the deceased on <u>11/3/68</u> , 19 <u>  </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Dr. Antonius Glahn</u>						DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 11/3/68
22d. PHYSICIAN'S NAME (Type) Antonius Glahn, M.D.						22e. ADDRESS Springfield State Hospital Sykesville, Maryland 21784				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			11-8-68		Baltimore National			Baltimore, Maryland		
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Charles R. Law 802 Madison Ave.						NOV 13 1968		<u>Charles Judge</u>		

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REMARKS OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
15754										
15769										
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR		
First MARY					Middle -			Last GRIMM		
3. SEX					4. RACE			5. DATE OF BIRTH		
Female					White			02-09-83		
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
Maryland					U.S.A.			9. COUNTY OF DEATH		
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		
Sykesville, Md.					Springfield State Hosp.			unknown		
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE					13b. COUNTY			13c. CITY OR TOWN		
Md.					Balti. City			Baltimore		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		
First Middle Last					First Middle Last			Yes, no, or unknown (If yes give war or dates of service)		
UNKNOWN					Mary			No		
17. INFORMANT					18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Myocardial infarction. DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension generalized severe. DUE TO, OR AS A CONSEQUENCE OF (c) 4301			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					Schizophrenic Reaction, hebephrenic type.					
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
					HOUR A.M. Month Day Year P.M. 19					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION		
								Street or R.F.D. No. City or Town County State		
22a. I certify that (X) (this hospital) attended the deceased from 12-26-44, to 11-11-68, that (X) (we) last saw the deceased alive on 11-11-68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					22c. DATE SIGNED					
Renee D. Espina, M.D.					11/11/68					
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
R. Espina, M.D.					Springfield State Hospital Sykesville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		
Burial					14 NOV 1968			New Cathedral Cemetery		
23d. LOCATION (City or Town) (County) (State)					23e. REC'D BY REGISTRAR			23f. REGISTRAR'S SIGNATURE		
Baltimore, Maryland					DATE NOV 15 1968			Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15755		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				15770					
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR			
Bertie			Maria	GROSSNICKLE	November 24, 1968		7:30 AM				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR			
female		white		9-27-1886		8102 YRS.		MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		U.S.A.				Carroll Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Sykesville		Springfield State Hospital		Housework							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Md.		Frederick		Myersville							
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Mahlon			Grossnickle	Alice	Gaver	Alice			Gaver		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address					
no			220-54-6006			Springfield State Hosp., Sykesville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia.										days	
DUE TO, OR AS A CONSEQUENCE OF (b) Infected bed sores.										weeks	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 715X											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
Schizophrenic reaction, hebephrenic type.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 2-17-26, 19__, to 11-24-68, 19__, that (I) (we) last saw the deceased alive on 11-24-68, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Paul G. Ensor, M.D.					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 11/24/68				
22d. PHYSICIAN'S NAME (Type) Paul G. Ensor, M.D.					22e. ADDRESS Springfield State Hospital Sykesville, Maryland 21784						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		Nov. 27-1968		Mt. Olivet Cemetery		Frederick- Md.		21701			
24. FUNERAL DIRECTOR Elwood T. M.R. Etchison & Son					ADDRESS Whitmore Frederick, Md. 21701		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
							DATE NOV 27 1968		f Charles Judge		

RECORD OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

15756		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				15771																	
CERTIFICATE OF DEATH																							
1. DECEASED-NAME : (Type or print) <b>Mary</b>			First <b>G.</b>			Middle <b>Hanigan</b>			Last			2a. DATE OF DEATH <b>11</b> Month <b>19</b> Day <b>68</b> Year			2b. HOUR <b>2 a</b> M								
3. SEX <b>Female</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>Nov. 6, 1895</b>			6. AGE (In years last birthday) <b>73</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN								
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Carroll</b> Md.														
10. CITY OR TOWN OF DEATH <b>Sykesville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Route 2</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Howard</b>			13c. CITY OR TOWN <b>Marriottsville</b>			13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>			13e. STREET AND NUMBER <b>R.D.</b>											
14. FATHER'S NAME <b>Enoch</b>			First <b>T.</b>			Middle <b>Selby</b>			Last			15. MOTHER'S MAIDEN NAME <b>Annie</b>			First <b>Brangel</b>			Middle <b>Brangel</b>			Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>217-24-2300A</b>			17. INFORMANT <b>James R. Hanigan</b>			Address <b>Terrace Dale</b> <b>Towson, Md. 21204</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>2509</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes Mellitus</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>10 yrs.</b> <b>10 yrs.</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>260x</b> <b>Chronic heart failure</b>																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																	
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State																	
22a. I certify that (I) (this hospital) attended the deceased from <b>Aug. 8</b> , 19 <b>59</b> , to <b>Sept. 30</b> <b>68</b> , that (I) (we) last saw the deceased alive on <b>Sept. 30</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE <b>Sani Okutman</b>			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/>			STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>Nov. 19, 1968</b>								
22d. PHYSICIAN'S NAME (Type) <b>Sani Okutman, M.D.</b>			22e. ADDRESS <b>Obrecht Road, Sykesville, Md.</b>																				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>11/22/1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Mt. View Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Howard, Md.</b>														
24. FUNERAL DIRECTOR <b>C. M. Waltz</b>			ADDRESS <b>Box 241, Sykesville, Md.</b>			25a. REC'D BY REGISTRAR <b>NOV 22 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>														

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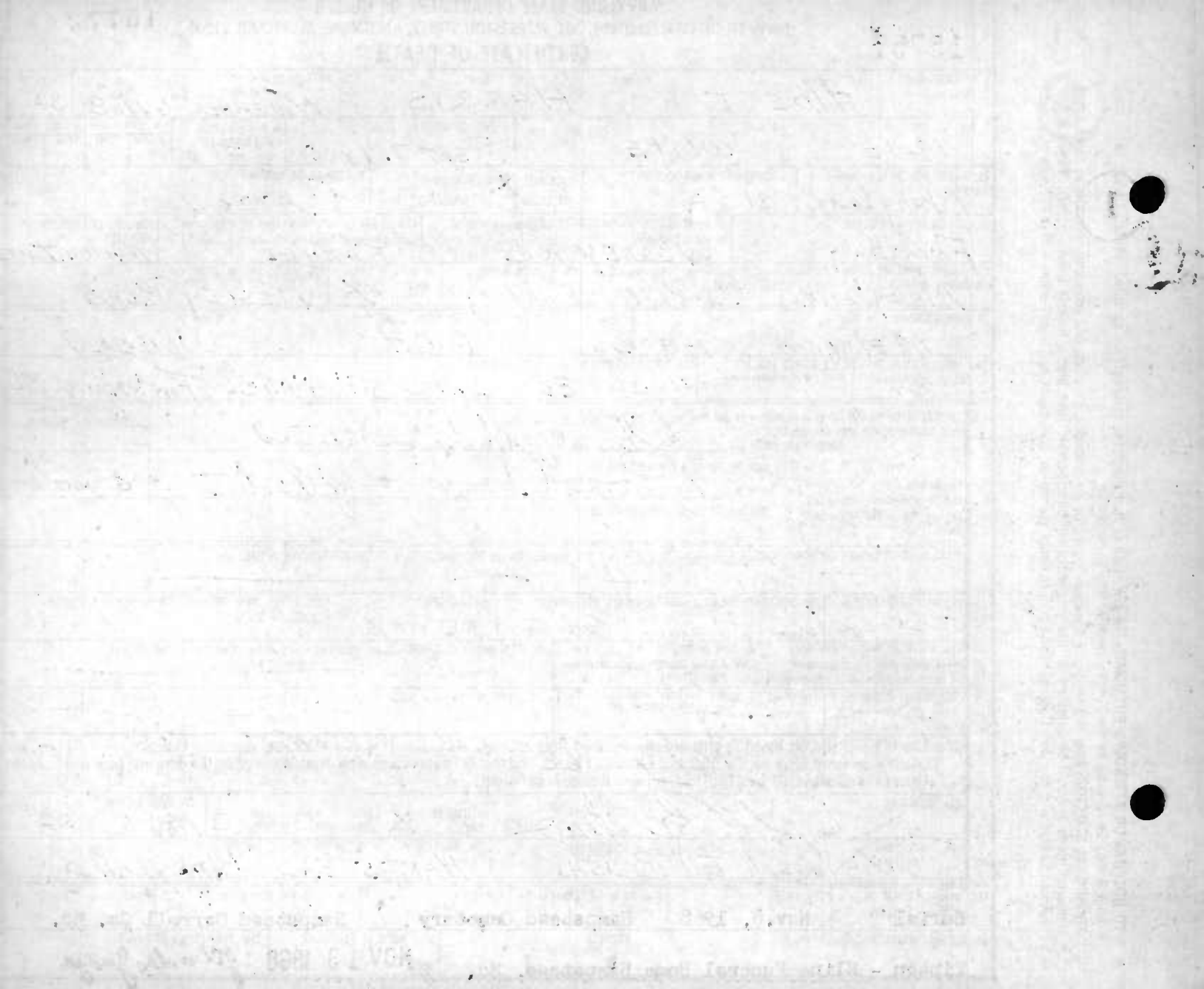
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>ALBERT</b>			First <b>HARRIS</b> Middle <b>HARRIS</b> Last <b>HARRIS</b>			2a. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>6</b> Year <b>1968</b>			2b. HOUR <b>3A.</b> M
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>SEPT 7. 1900</b>		6. AGE (In years last birthday) <b>68</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL</b> Md.			
10. CITY OR TOWN OF DEATH <b>Finksburg</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>WESLEY RD</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>FARMER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Agriculture</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Finksburg</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>WESLEY ROAD</b>	
14. FATHER'S NAME First <b>MELOIR</b> Middle <b>HARRIS</b> Last <b>HARRIS</b>			15. MOTHER'S MAIDEN NAME First <b>EDITH</b> Middle <b>WOLLERY</b> Last <b>WOLLERY</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>216-22-9780</b>		17. INFORMANT Address <b>Lillie Rill HARRIS Finksburg MD</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of Prostate</b> <b>1541</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Primary Carcinoma of Prostate</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>6 yrs</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 yrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>154X</b>									
19a. DATE OF OPERATION <b>3-25-62</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Primary Carcinoma of Prostate</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR <b></b> A.M. <b></b> Month <b></b> Day <b></b> Year <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. <b></b> City or Town <b></b> County <b></b> State <b></b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>March 23</b> , 1962, to <b>Nov 6</b> , 1968, that (I) (we) last saw the deceased alive on <b>Nov 4</b> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Joseph E. Bush</b>				DEGREE <b></b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>NOV 6 1968</b>			
22d. PHYSICIAN'S NAME (Type) <b>JOSEPH E. BUSH</b>				22e. ADDRESS <b>HAMPSTEAD MARYLAND</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Nov. 8, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hampstead Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hampstead Carroll Co. Md.</b>			
24. FUNERAL DIRECTOR <b>Tipton - Eline Funeral Home Hampstead, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 13 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15758

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

15773

1. DECEASED-NAME (Type or print) <b>KATIE E. HARRIS</b>			2a. DATE OF DEATH <b>Nov 26</b> Day <b>1968</b> Year <b>1968</b>			2b. HOUR <b>10:35</b> AM			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>OCT. 26, 1894</b>		6. AGE (In years last birthday) <b>74</b> YRS.		IF UNDER 1 YEAR MONTHS <b>7</b> DAYS <b>10</b> HOURS <b>35</b> MIN.	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL Co.</b> Md.			
10. CITY OR TOWN OF DEATH <b>WESTMINSTER</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>CARROLL Co. GEN. Hosp. HOUSE-WIFE</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>CARROLL Co.</b>		13c. CITY OR TOWN <b>WESTMINSTER</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>190 LIBERTY ST.</b>	
14. FATHER'S NAME First <b>JACKSON</b> Middle <b>MERLY</b> Last <b>JONES</b>			15. MOTHER'S MAIDEN NAME First <b>FLORENCE S.</b> Middle <b>JONES</b> Last <b>JONES</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. <b>218-40-4765A</b>		17. INFORMANT <b>GEO. M. HARRIS</b>		Address <b>SAME ADDRESS</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intractable Heart failure</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atherosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4200</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 10, 1968</b> , to <b>Nov 26, 1968</b> , that (I) (we) last saw the deceased alive on <b>Nov 26, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>John S. Harsney</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>11/26/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>JOHN S. HARSNEY, MD</b>				22e. ADDRESS <b>8 Ancho St. Westminster, Md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>11/29/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>KRIDERS CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>WESTMINSTER MD</b>			
24. FUNERAL DIRECTOR <b>J. S. Harsney, Westminster, Md</b>				25a. REC'D BY REGISTRAR <b>DEC 2 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

CERTIFICATE OF MARRIAGE

STATE OF OHIO, COUNTY OF CUYAHOGA, CITY OF CLEVELAND

1913

KATIE

WHITE

FEMALE

BORN N. 21

MARRIED

CHAS. E. CO. (GIRL) MARRIED

WESTMINSTER

PROBATION

CHAS. E. CO. (GIRL) MARRIED

NO. 1000 27

JACKSON

MARRIED

PROBATION

NO. 1000 27

218-44-4424 (GIRL) MARRIED

218-44-4424 (GIRL) MARRIED

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218-44-4424 (GIRL) MARRIED

218-44-4424 (GIRL) MARRIED

CHAS. E. CO. (GIRL) MARRIED

NO. 1000 27

NO. 1000 27



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15759

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15774

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>CHARLES HENRY HORTON</b>			2a. DATE OF DEATH Month <b>Nov</b> Day <b>9</b> Year <b>1968</b>			2b. HOUR <b>8 A.M.</b>			
3. SEX <b>M.</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>2/18/1878</b>		6. AGE (In years last birthday) <b>90</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL</b>			
10. CITY OR TOWN OF DEATH <b>NEW WINDSOR</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>HORTON BOARDING HOME</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>FARMER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>CARROLL</b>		13c. CITY OR TOWN <b>UNIONTOWN</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>RURAL</b>	
14. FATHER'S NAME First <b>IRA L. HORTON</b> Middle <b>H.</b> Last <b>HORTON</b>			15. MOTHER'S MAIDEN NAME First <b>MIRIAM C. WRIGHT</b> Middle <b>C.</b> Last <b>WRIGHT</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>NO</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>RALPH HORTON, NEW WINDSOR MD</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4129 Arteriosclerotic C.V.D.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>years</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4221</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Aug 1</b> , 19 <b>44</b> , to <b>11/9/68</b> , that (I) (we) last saw the deceased alive on <b>11/7/68</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>M.E. Robertson MD</b>				DEGREE <b>MD</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>11/9/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>NEW WINDSOR MD</b>				22e. ADDRESS <b>M.E. ROBERTSON</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>11/12/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BETHEL CEM.</b>		23d. LOCATION (City or Town) (County) (State) <b>CARROLL COUNTY MD</b>			
24. FUNERAL DIRECTOR <b>W. H. Hutzler &amp; Sons, New Windsor, Md.</b>				ADDRESS		25a. REC'D BY REGISTRAR DATE <b>NOV 12 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

1377

REPUBLIC OF THE COUNTRY

1377



NOV 13 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15760										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										15775	
1. DECEASED-NAME (Type or print) Charles Robert HUNDLEY										2a. DATE OF DEATH Month Day Year November 30, 1968										2b. HOUR 8:45 P.M.	
3. SEX male			4. RACE white			5. DATE OF BIRTH 4-29-1897			6. AGE (In years last birthday) 71 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.							
7a. BIRTHPLACE (State or foreign country) N. Carolina			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Carroll Md.												
10. CITY OR TOWN OF DEATH Sykesville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) painter			12b. KIND OF BUSINESS OR INDUSTRY												
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY —			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3801 Roland Avenue										
14. FATHER'S NAME First Middle Last Samuel Hundley					15. MOTHER'S MAIDEN NAME First Middle Last Unknown																
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) no			16b. SOCIAL SECURITY NO. 245-01-9664			17. INFORMANT Address Springfield State Hospital, Sykesville, Md.															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 492X IMMEDIATE CAUSE (a) Congestive heart failure. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary emphysema. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 5271																					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?												
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)														
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from 11-15-68, 19__, to 11-30-68, 19__, that (X) (we) last saw the deceased alive on 11-30-68, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																					
22b. SIGNATURE Gracito V. Patricio, M.D.						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 11/30/68													
22d. PHYSICIAN'S NAME (Type) Gracito V. Patricio, M.D.						22e. ADDRESS Springfield State Hospital Sykesville, Maryland 21784															
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Dec 4, 1968		23c. NAME OF CEMETERY OR CREMATORY Lake view Cemetery			23d. LOCATION (City or Town) (County) (State) Carroll Co. Md.													
24. FUNERAL DIRECTOR Sally Funeral Home						ADDRESS 231 W. 36th St.		25a. REC'D BY REGISTRAR DEC 4 1968		25b. REGISTRAR'S SIGNATURE Charles Judge											

13781

11-61



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 415 M  
30M REV 11-68

15761

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15776

1. DECEASED-NAME (Type or print) <b>Benjamin F. Jackson</b>			2a. DATE OF DEATH Month <b>Nov.</b> Day <b>2</b> Year <b>1968</b>			2b. HOUR M <b></b>					
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Oct. 20, 1896</b>		6. AGE (In years last birthday) <b>72</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN <b></b>	
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b> Md.					
10. CITY OR TOWN OF DEATH <b>Hampstead</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Shiloh Ave.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Carpenter</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Hampstead</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>Shiloh Ave.</b>		
14. FATHER'S NAME First <b>Caleb</b> Middle <b>Jackson</b> Last <b></b>			15. MOTHER'S MAIDEN NAME First <b>Judy Ann</b> Middle <b>Bolte</b> Last <b></b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input checked="" type="checkbox"/> (If yes, give year or dates of service) <b>WWI</b>			16b. SOCIAL SECURITY NO. <b>218-07-1600</b>		17. INFORMANT <b>Mary Jackson</b>			Address <b>Hampstead, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4109 Cardiac Infarction</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>(b) Arteriosclerotic C.V. Disease</b> DUE TO, OR AS A CONSEQUENCE OF <b>(c)</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b> <b>5 years</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4201 Emphysema</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>2-23-68</b> , 19 <b>68</b> , to <b>11-2-68</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10-31-68</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <b>M.C. Porterfield</b>						DEGREE <b></b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>11-2-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>M.C. Porterfield, M.D.</b>						22e. ADDRESS <b>Hampstead, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Nov. 4, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Finksburg Carroll Co. Md.</b>					
24. FUNERAL DIRECTOR <b>Tipton - Eline Funeral Home Hampstead, Md.</b>						25a. REC'D BY REGISTRAR DATE <b>NOV 7 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

# DECLARATION OF WAR

Nov. 8, 1918

Legation, F. Jackson

Col. W. H. H.

State

Gen. H. H.

USA

Gen. H. H.

Gen. H. H.

Gen. H. H.

Gen. H. H.

Gen. H. H.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
30M REV. 7-68

15762

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15777

# CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last <b>John Henry JACKSON</b>			2a. DATE OF DEATH Month Day Year <b>Nov. 14 1968</b>		2b. HOUR <b>8:00 A.M.</b>
3. SEX <b>Male</b>	4. RACE <b>Negro</b>	5. DATE OF BIRTH <b>May 4, 1908</b>		6. AGE (In years last birthday) <b>60</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b>	
10. CITY OR TOWN OF DEATH <b>Sykesville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Hodges Rd.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Cook</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>		13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Carroll</b>	
13c. CITY OR TOWN <b>Sykesville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Hodges Rd.</b>	
14. FATHER'S NAME First Middle Last <b>Rafeield - JACKSON</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Lottie - BROWN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>216-18-5083</b>		17. INFORMANT <b>Mrs. Rose Marie Jackson</b>	
				Address <b>Sykesville, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>A.S.C. V.D. &amp; CARDIAC FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4201</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 MIN.</b> <b>10 YRS.</b>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>OCT. 1967</b> to <b>11-14</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive, on <b>11-14</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>R. V. Houck</b> M.D.		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>11-15-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>R. V. Houck</b>		22e. ADDRESS <b>Sykesville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11-17-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Carroll Hill Cemetery</b>	
23d. LOCATION (City or Town) (County) (State) <b>new Station Md.</b>					
24. FUNERAL DIRECTOR <b>Harry Wm Haight</b>		ADDRESS <b>Sykesville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 20 1968</b>	
				25b. REGISTRAR'S SIGNATURE <b>James J. Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <b>WILLIAM HENRY JOHNSON</b>						2a. DATE OF DEATH Month <b>11</b> Day <b>5</b> Year <b>68</b>			2b. HOUR <b>3:15</b> MIN <b>M</b>		
3. SEX <b>Male</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH <b>09/27/06</b>			6. AGE (In years last birthday) <b>62</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>
7a. BIRTHPLACE (State or foreign country) <b>Dist. of Col.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Carroll</b> Md.				
10. CITY OR TOWN OF DEATH <b>Sykesville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield State Hosp.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Janitor</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Jessup</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
14. FATHER'S NAME First <b>Edward</b> Middle <b>Johnson</b> Last <b>Johnson</b>				15. MOTHER'S MAIDEN NAME First <b>Daisy</b> Middle <b>Bush</b> Last <b>Bush</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>214-01-8802</b>		17. INFORMANT <b>Hospital Records</b> Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>437.9</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>331.8</b> (b) <b>Cerebral vascular accident bilateral</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>months</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o) <b>CBS assoc. with cerebral arteriosclerosis, without qualifying phrase</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (this hospital) attended the deceased from <b>09/09/68</b> 19 <b>68</b> , to <b>11/05</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Suha Ozgun</b>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>11/05/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Suha Ozgun, M. D.</b>						22e. ADDRESS <b>Springfield State Hospital, Sykes., Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>11-9-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CARVER MEMORIAL</b>			23d. LOCATION (City or Town) (County) (State) <b>LAUREL Md.</b>				
24. FUNERAL DIRECTOR <b>JOSEPH KNIGHT</b>						ADDRESS <b>1639 N BROADWAY</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 7 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>	

REPORT OF THE

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NAME OF PERSON		ADDRESS		CITY		STATE		COUNTY		POST OFFICE		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

15764 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 15779  
Item#6, Film#406 11/20/68 km CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Theresa I Kelley</i>			2a. DATE OF DEATH Month <i>November</i> Day <i>12</i> Year <i>1968</i>			2b. HOUR <i>4:20 PM</i>					
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH		6. AGE (In years last birthday) <i>50</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Pa.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Carroll</i>					
10. CITY OR TOWN OF DEATH <i>Sykesville</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Liberty Road</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>BEAUTICIAN</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>HAIR</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>Carroll</i>		13c. CITY OR TOWN <i>Sykesville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>Liberty Road</i>		
14. FATHER'S NAME First Middle Last <i>Louis - Pecoraro</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Jennie - Santo</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i>			16b. SOCIAL SECURITY NO. <i>218 146723</i>		17. INFORMANT Address <i>Mr. John Kelley Sykesville Md.</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>FULMINATING PNEUMONIA BOTH LUNGS</i> <i>174X</i> DUE TO, OR AS A CONSEQUENCE OF, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>METASTATIC CARCINOMA OF LEFT BREAST</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>CARCINOMA LEFT BREAST</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days.</i> <i>3 YRS.</i> <i>10 YRS.</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>170X</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <i>C.O.T.</i> , 19 <i>56</i> , to <i>11-12</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>11-12</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>R. V. Houck, Jr. M.D.</i>					22c. DATE SIGNED <i>11-13-68</i>						
22d. PHYSICIAN'S NAME (Type) <i>R. V. Houck, Jr.</i>					22e. ADDRESS <i>Sykesville, Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>11-15-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Moreland Memorial</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore Md.</i>					
24. FUNERAL DIRECTOR <i>Harry Eben Haight</i>					25a. REC'D BY REGISTRAR <i>Sykesville, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

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UNITED STATES DEPARTMENT OF AGRICULTURE

CERTIFICATE OF DEATH

1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of birth: \_\_\_\_\_

5. Place of birth: \_\_\_\_\_

6. Date of death: \_\_\_\_\_

7. Place of death: \_\_\_\_\_

8. Cause of death: \_\_\_\_\_

9. Signature of physician: \_\_\_\_\_

10. Signature of registrar: \_\_\_\_\_

11. Signature of informant: \_\_\_\_\_

12. Name of informant: \_\_\_\_\_

13. Address of informant: \_\_\_\_\_

14. City: \_\_\_\_\_

15. State: \_\_\_\_\_

16. Zip: \_\_\_\_\_





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15765		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				15780			
1. DECEASED-NAME (Type or print) First Middle Last <b>Alberta Christine Larkins</b>						2a. DATE OF DEATH Month Day Year <b>Nov 29 1968</b>		2b. HOUR <b>9:12</b> M	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>July 23, 1889</b>		6. AGE (in years last birthday) <b>79</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll County</b> Md.			
10. CITY OR TOWN OF DEATH <b>Westminster</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Carroll Co. Gen. Hosp.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>---</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Owings Mills</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>5 Montgomery Road</b>	
14. FATHER'S NAME First Middle Last <b>William Thomas Pearle</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Sarah Ida Grushon</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown? <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>216030-6737</b>		17. INFORMANT <b>Charles Kern Randall</b> Address <b>9908 Oak Glen Rd., Randallstown, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b> <b>4120</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>443X</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 29, 1968</b> , to <b>Nov 29, 1968</b> , that (I) (we) last saw the deceased alive on <b>Nov 29, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>John S. Harshey, M.D.</b>		22c. DATE SIGNED <b>11/29/68</b>		22d. PHYSICIAN'S NAME (Type) <b>JOHN S. HARSHEY, M.D.</b>				22e. ADDRESS <b>8 Archer St. Westminster, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Dec. 2, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>All Saints Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Reisterstown, Balto, Md.</b>			
24. FUNERAL DIRECTOR <b>H. J. Eckhardt</b>		ADDRESS <b>Owings Mills, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 3 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div style="text-align: center;"> <b>CERTIFICATE OF DEATH</b>  <div style="float: left;">15768</div> <div style="float: right;">15781</div> </div>									
1. DECEASED-NAME (Type or print)			First Middle Last Charles Mitchell Lindsey			2a. DATE OF DEATH Month Day Year November 7, 1968		2b. HOUR 4:15 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 11-24-80		6. AGE (In years lost birthday) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) U.S.A.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll County, Md.			
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Machinist		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. CITY OR TOWN Baltimore City		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3757 Keswick Road		
14. FATHER'S NAME First Middle Last Amos T. Lindsey			15. MOTHER'S MAIDEN NAME First Middle Last Unk.						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (or unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO. 215-16-5472		17. INFORMANT Address Records, Springfield State Hospital				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral lobular pneumonia 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4200 (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days Years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. Chronic brain syndrome associated with senile brain disease with psychotic reac.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 6-14, 1965, to 11-7, 1968, that (I) (we) last saw the deceased alive on 11-7-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Octavio A. Ruiz, M.D.					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 11-7-68		
22d. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M.D.					22e. ADDRESS Springfield State Hospital, Sykesville, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 11/11/68		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore Md.			
24. FUNERAL DIRECTOR Austin E. Donovan-3818 Roland Ave.					25a. REC'D BY REGISTRAR NOV 12 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

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UNITED STATES OF AMERICA

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Department of the Interior

Office of the Secretary

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

15767		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				15782					
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR M			
DANIEL					LIPPY	NOV 10 1968		1P			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
Male		White		MARCH 16 - 1897		77 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Md.					
Maryland		USA				Carroll					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
MANCHESTER						Farmer			Farmer		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Carroll		MANCHESTER				Rural		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
Charles Wesley Lippy			Ellen Wertz								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address						
No			319-360359		Mrs Daniel LIPPY MANCHESTER, Md						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 4310 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 MIN 8 yrs 8 yrs											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 331X											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (1) (this hospital) attended the deceased from Sept 1955, to Nov 10, 1968, that (1) (we) last saw the deceased alive on Nov 1, 1968, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE W. H. Foard M.D.			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 11-10-68			
22d. PHYSICIAN'S NAME (Type) W. H. Foard M.D.			22e. ADDRESS MANCHESTER, Md 21102								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 11/13/68		23c. NAME OF CEMETERY OR CREMATORY Manchester Cemetery		23d. LOCATION (City or Town) (County) (State) Manchester Md Carroll Co				
24. FUNERAL DIRECTOR Wayne V. Penworthy			ADDRESS Hanover Penna			25a. REC'D BY REGISTRAR DATE NOV 18 1968		25b. REGISTRAR'S SIGNATURE Judge			

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10. 11. 1941



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1514  
30M REV. 1-69

15768		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		15783	
Item#6Film#G407 12/4/68 vmp					
1. DECEASED-NAME (Type or print) First Middle Last RALPH ROBERT LITTLE			2a. DATE OF DEATH Month Day Year Nov 24 68		2b. HOUR 8 31 A M
3. SEX M	4. RACE W		5. DATE OF BIRTH 18 JAN 1906		6. AGE (In years last birthday) 68 YRS.
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH CARROLL		10. CITY OR TOWN OF DEATH WESTMINSTER			
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WESTMINSTER		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) PHOTO-MECHANIC		12b. KIND OF BUSINESS OR INDUSTRY Garage	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. CITY OR TOWN WESTMINSTER		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13d. STREET AND NUMBER 126 E. MAIN ST.		14. FATHER'S NAME First Middle Last LEWIS - LITTLE			
15. MOTHER'S MAIDEN NAME First Middle Last BERVINA Viola Babylon		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO. 214-01-0503		17. INFORMANT Address MRS. MAUDE G. LITTLE 126 E. Main St. Westminster, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) Diabetic Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Approximate interval between onset and death: 2509 Minutes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 260X Years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Chronic mild alcoholism.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. LOCATION Street or R.F.D. No. City or Town County State	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Sep 26, 1964, to Nov 9, 1968, that (I) (we) last saw the deceased alive on Nov 9, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE V. M. BUSLER, Jr. M.D.		22c. DATE SIGNED Nov 26, 1968		22d. PHYSICIAN'S NAME (Type) V. M. BUSLER, Jr.	
22e. ADDRESS 245 Baltimore St., Hanover, Pa.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b. DATE 11/27/68		23c. NAME OF CEMETERY OR CREMATORY EVERGREEN MEM. GARDENS		23d. LOCATION (City or Town) (County) (State) FINKSBURG MD	
24. FUNERAL DIRECTOR J. J. Myers, Jr., Westminster, Md.		25a. REC'D BY REGISTRAR DEC 2 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

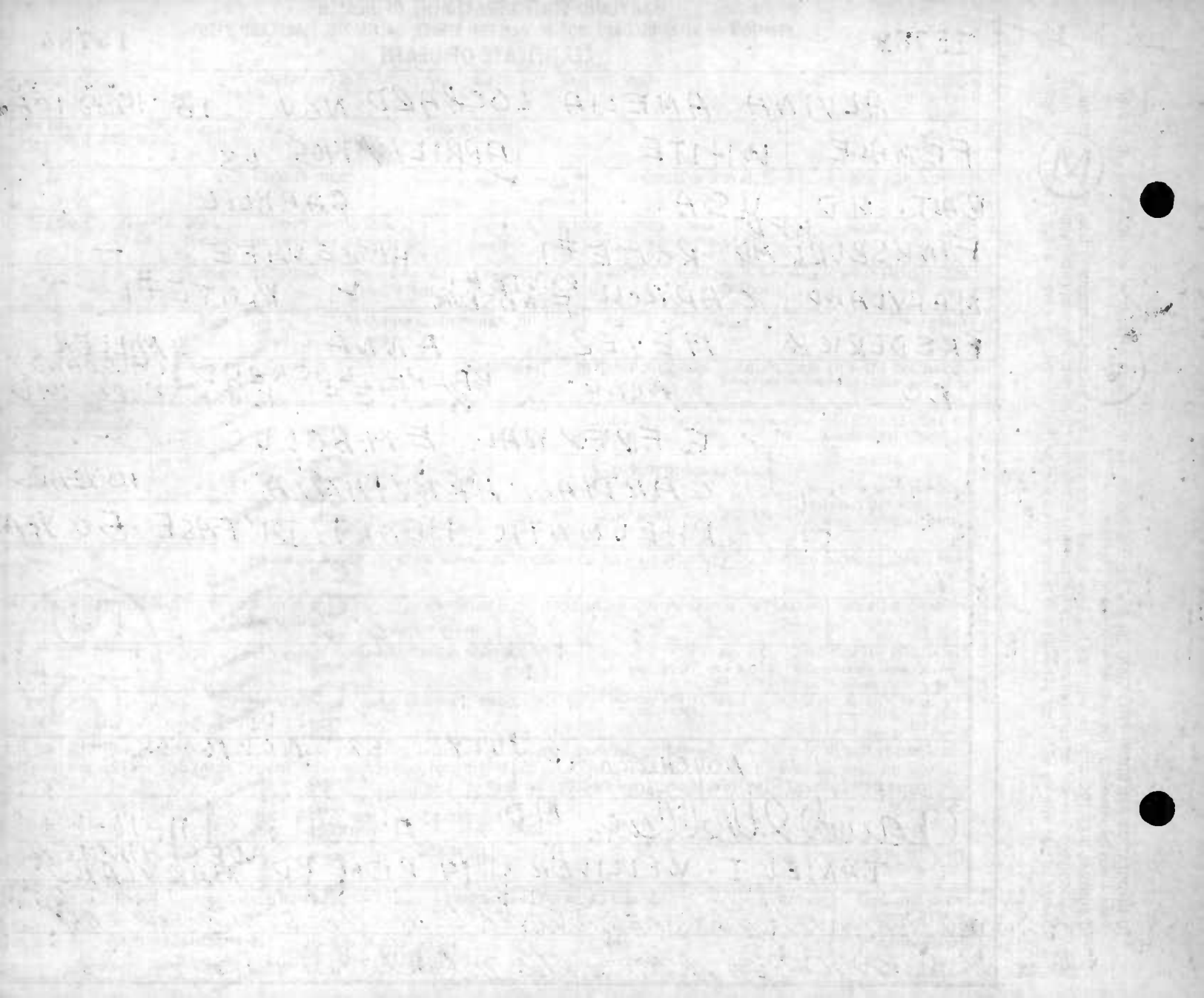
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15769

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

15784

1. DECEASED-NAME (Type or print) <b>ALVINA AMELIA LOCKARD</b>			2a. DATE OF DEATH Month <b>NOV</b> Day <b>16</b> Year <b>1968</b>			2b. HOUR <b>1:00 AM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>APRIL 17 1905</b>		6. AGE (In years last birthday) <b>63</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>BALT. MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL</b> Md.	
10. CITY OR TOWN OF DEATH <b>FINKSBURG MD</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>ROUTE #1</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSE WIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>CARROLL</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET AND NUMBER <b>ROUTE #1</b>	
14. FATHER'S NAME First <b>FREDERICK</b> Middle <b>MEYER</b> Last <b>—</b>			15. MOTHER'S MAIDEN NAME First <b>ANNA</b> Middle <b>—</b> Last <b>MILLER</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <b>NO</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>RALPH LOCKARD (HUSBAND) ROUTE #1 FINKSBURG MD</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL EMBOLUS</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARDIAC ARRHYTHMIA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>RHEUMATIC HEART DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>398X</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 YEARS</b> <b>50 YEARS</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c) <b>416X</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>JULY</b> , 1957, to <b>NOV 16</b> , 1968, that (I) (we) lost saw the deceased alive on <b>NOVEMBER 16 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Daniel I. Welliver M.D.</b> DEGREE <b>—</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <b>11-16-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>DANIEL I. WELLIVER.</b>				22e. ADDRESS <b>14 RIDGE RD WESTMINSTER MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11/19/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WESTMINSTER CEM.</b>		23d. LOCATION (City or Town) (County) (State) <b>WESTMINSTER MD.</b>	
24. FUNERAL DIRECTOR <b>J. S. Myers, Jr., Westminster, Md.</b> ADDRESS <b>—</b>				25a. REC'D. BY REGISTRAR <b>NOV 20 1968</b> DATE		25b. REGISTRAR'S SIGNATURE <b>—</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH Month Day Year		2b. HOUR A M	
AMELIA		(MRS) M.		LUCAS				NOVEMBER 20, 1968		5:20 A	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Female		White		6-9-1890		78 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		U.S.A.				Carroll					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Sykesville		Springfield State Hospital		Saleslady							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Baltimore City		Baltimore				1 West 22nd Street			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
Henry		A,		Lucas				Katherine		Schultz	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No				215-10-6619		Records, Springfield State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4200</u> (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days Years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>CBS assoc. with cerebral arteriosclerosis, with psychotic reaction</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>7-28-66</u> , 19____, to <u>11-20-68</u> , 19____, that (I) (we) last saw the deceased alive on <u>11-20-68</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Dr. Antonius Glahn</u>		22c. DATE SIGNED 11-20-68		22d. PHYSICIAN'S NAME (Type) Antonius Glahn, M.D.		22e. ADDRESS Springfield State Hospital Sykesville, Maryland 21784					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 11/23/68.		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.					
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		ADDRESS		25a. REC'D BY REGISTRAR NOV 22 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					





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15771

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15786

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>FLORENCE V</b>			First Middle Last			2a. DATE OF DEATH Month <b>11</b> Day <b>26</b> Year <b>68</b>			2b. HOUR <b>9:15</b> M		
3. SEX <b>FEMALE</b>			4. RACE <b>WHITE</b>			5. DATE OF BIRTH <b>5-11-1883</b>			6. AGE (In years lost birthday) <b>85</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>CARROLL</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>CARROLL</b>		
10. CITY OR TOWN OF DEATH <b>MANCHESTER MD</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Longview Nursing Home</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>			13b. COUNTY <b>Carroll</b>			13c. CITY OR TOWN <b>RT. 6 Westminster MD</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME <b>GEORGE</b>			First Middle Last			15. MOTHER'S MAIDEN NAME <b>MARY</b>			First Middle Last <b>GLASS</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b>			16b. SOCIAL SECURITY NO. <b>212-50-1026</b>			17. INFORMANT <b>WILBUR W MAGIN</b>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure (acute)</b> 4409 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis General</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Senility</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6-8 hrs</b> <b>years</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o) <b>4500</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>11-13</b> , 19 <b>68</b> , to <b>11-26</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>11-26</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>W. Glenn Speicher</b>						DEGREE <b>MD</b>			22c. DATE SIGNED <b>11-26-68</b>		
22d. PHYSICIAN'S NAME (Type) <b>W. Glenn Speicher</b>						22e. ADDRESS <b>1358 Wain St Westminster Md 21157</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>11/29/1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Taylorsville</b>			23d. LOCATION (City or Town) (County) (State) <b>Carroll, Md.</b>		
24. FUNERAL DIRECTOR <b>C. M. Waltz, Box 241, Sykesville, Md.</b>						25a. FILED BY REGISTRAR <b>DEC 2 1968</b>			25b. REGISTRAR'S SIGNATURE <b>John Judge</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARTLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
15778										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) <b>Bessie M. Martin</b>					2a. DATE OF DEATH Month <b>Nov.</b> Day <b>4</b> Year <b>1968</b>			2b. HOUR <b>3:55</b> M		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>March 19, 1891</b>		6. AGE (In years last birthday) <b>77</b> YRS.		IF UNDER 1 YEAR MONTHS <b>77</b> DAYS <b>77</b> HOURS <b>77</b> MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b> Md.				
10. CITY OR TOWN OF DEATH <b>Westminster</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Carroll Co. Hospt.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Greenmount</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>RD</b>	
14. FATHER'S NAME First Middle Last <b>George Stoffle</b>					15. MOTHER'S MAIDEN NAME First Middle Last <b>Mary (Unknown)</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>216-09-9532</b>		17. INFORMANT Address <b>W. Albert Ruby Hampstead, Md. 21074</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> <b>1531</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of the Transverse Colon</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>1531</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>10/23, 1968</b> , to <b>11/4, 1968</b> , that (I) (we) last saw the deceased alive on <b>11/4, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.										
22b. SIGNATURE <b>John S. Harehey, MD</b>					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>11/4/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>JOHN S. HAREHEY MD</b>					22e. ADDRESS <b>8 Andover St. Westminster, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Nov. 7, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Leisters Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Westminster Carroll Co. Md.</b>				
24. FUNERAL DIRECTOR <b>Tipton - Eline Funeral Home Hampstead, Md.</b>					25a. REC'D BY REGISTRAR DATE <b>NOV 7 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

100-100000

UNITED STATES DEPARTMENT OF JUSTICE

Serial

Index

Name

Address

March 10, 1941

Mr.

USA

Chicago

Subject

Control No. 100-100000

Remarks

Notes

File

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100-100000

March 10, 1941

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <b>Anna Virginia Matthews</b>						2a. DATE OF DEATH <b>11</b> Month <b>14</b> Day <b>68</b> Year			2b. HOUR <b>4:45</b> PM		
3. SEX <b>female</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH <b>4/24/95</b>			6. AGE (In years last birthday) <b>73</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b>			Md.		
10. CITY OR TOWN OF DEATH <b>Rural--Sykesville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield State Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>domestic</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Ashton</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>none</b>		
14. FATHER'S NAME First Middle Last <b>Ozman - Snowden</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Joanna - Jopes</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) <b>no</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>214-18-7090</b>		17. INFORMANT Address <b>Springfield Hospital record, Sykesville, Md.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4129</b> (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Chronic brain syndrome associated with cerebral arteriosclerosis with behavioral reaction.</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>8/5/</b> , 19 <b>68</b> , to <b>11/14/</b> , 19 <b>68</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>11/14/</b> 19 <b>68</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.											
22b. SIGNATURE <b>Alfredo M. Labrit</b>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>11-14-1968</b>			
22d. PHYSICIAN'S NAME (Type) <b>Alfredo M. Labrit, M.D.</b>						22e. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>					
23a. RITUAL CREMATION, REMOVAL (Specify)		23b. DATE <b>11-18-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ebenezer Church</b>		23d. LOCATION (City or Town) (County) (State) <b>Ashton, Montg. Md.</b>					
24. FUNERAL DIRECTOR <b>George R. Snowden Lockwell</b>						25a. REC'D BY REGISTRAR <b>NOV 19 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

STATE OF TEXAS

County of \_\_\_\_\_

Know all men by these presents, \_\_\_\_\_

of the County of \_\_\_\_\_ State of Texas,

do hereby certify that \_\_\_\_\_

is the true and correct owner of \_\_\_\_\_

and that the same is subject to a lien in favor of \_\_\_\_\_

for the sum of \_\_\_\_\_ Dollars.

Given under my hand and the seal of said County, this \_\_\_\_\_ day of \_\_\_\_\_ 19\_\_\_\_.

\_\_\_\_\_

County Clerk

My commission expires \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

15776

15789

1. DECEASED-NAME (Type or print) <b>MARY ANN METCALFE</b>			2a. DATE OF DEATH 11 Month 21 Day 1948 Year 6 A.M.		
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH <b>NOV 17-1892</b>	6. AGE (In years last birthday) <b>76</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>CARROLL</b>		
10. CITY OR TOWN OF DEATH <b>WESTMINSTER</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>265 E MAIN ST.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>	13b. COUNTY <b>CARROLL</b>	13c. CITY OR TOWN <b>WESTMINSTER</b>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <b>265 E MAIN ST.</b>	
14. FATHER'S NAME First Middle Last <b>CHARLES GLISSAN</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>MARY KELLER</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>215-26-9756</b>	17. INFORMANT Address <b>GAVIN METCALFE WESTMINSTER MD</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic C.V.D.</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4221</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <b>1957</b> , 19, to <b>11/21</b> , 19 <b>48</b> , that (I) (we) last saw the deceased alive on <b>11/14/48</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>M.E. Robertson MD</b>			22c. DATE SIGNED <b>11/21/48</b>		DEGREE <b>MD</b>
22d. PHYSICIAN'S NAME (Type) <b>ME ROBERTSON</b>			22e. ADDRESS <b>NEW WINDSOR MD</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>11/23/68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>PIPE CREEK</b>		23d. LOCATION (City or Town) (County) (State) <b>NEW WINDSOR CARROLL MD</b>	
24. FUNERAL DIRECTOR <b>D.D. Hartzler Sons New Windsor</b>			25a. REC'D BY REGISTRAR DATE <b>NOV 25 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										15790
15775										
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR		
ELLA DORA MILBERRY					Nov 30 1948			2:15 AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR		
F		COL		AUG 14-1914		34 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
PENNA		USA				CARROLL				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
WESTMINSTER			DOA CARROLL CO			COOK		HOUSEWORK		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND			CARROLL		UNION BRIDGE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		NONE	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
JOSHUA GREEN			CECELIA (UNKNOWN)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
NO			215-20-8917		ROBERT MILBERRY UNION BRIDGE MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Cerebral Vascular accident									sudden	
4120 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
(b) Hypertensive C.V.D.									years	
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
443 X Diabetes Mellitus										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from 11/4/48, 19, to 11/30/48, 19, that (I) (we) last saw the deceased alive on 11/29/48, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE M.E. Robertson MD						22c. DATE SIGNED 11/30/48				
22d. PHYSICIAN'S NAME (Type) M E ROBERTSON						22e. ADDRESS New Windsor Md				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL			DEC 3-1948		ST JAMES		NEW WINDSOR RURAL MD			
24. FUNERAL DIRECTOR ADDRESS D S Hartzler & Sons Union Bridge Md						25a. REC'D BY REGISTRAR DATE DEC 3 1968		25b. REGISTRAR'S SIGNATURE		

1875

STATE OF TEXAS

DEPARTMENT OF AGRICULTURE

1875

1

Section of the State

Hydrographic Survey

United States Fish Commission

1875

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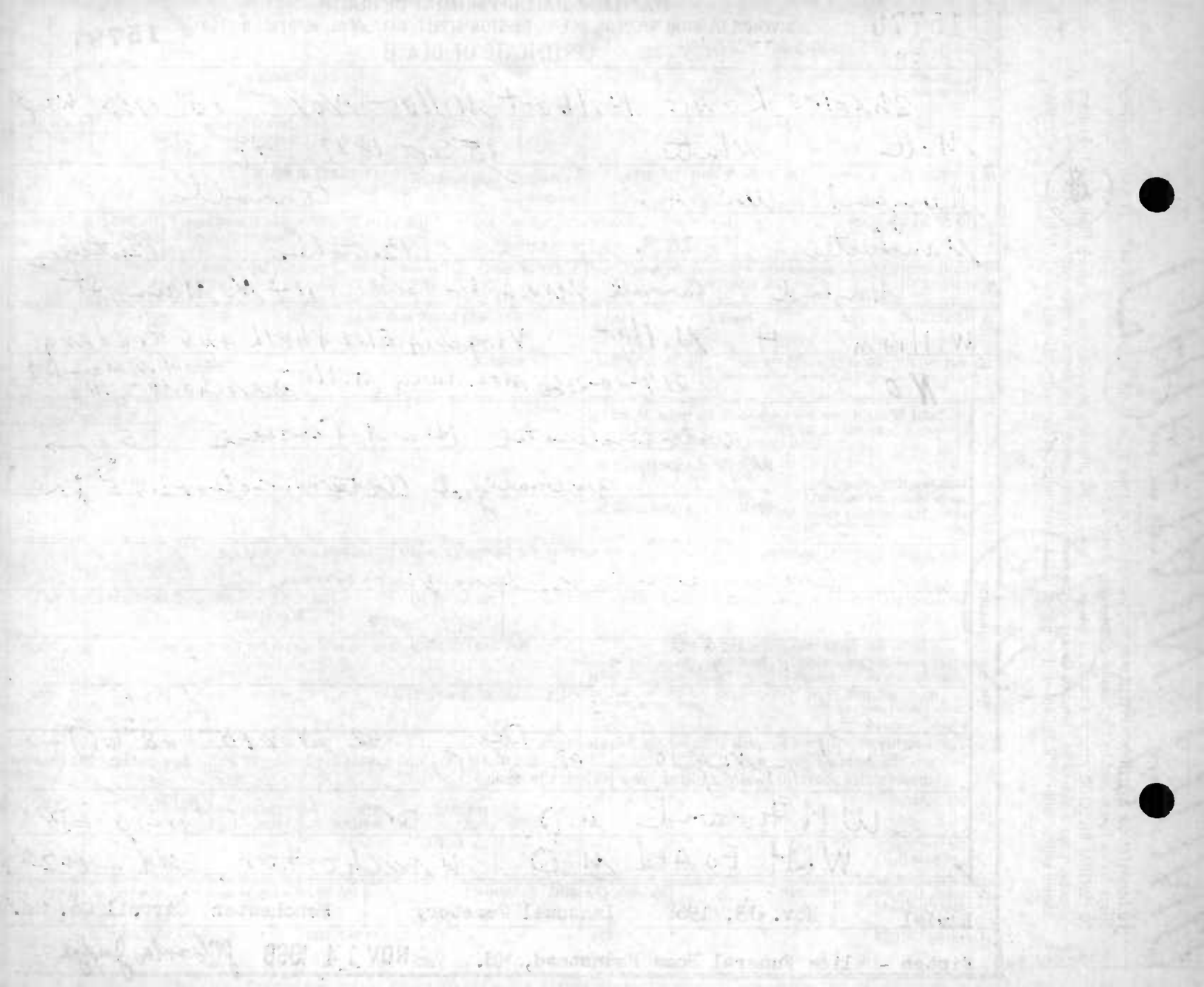
1875

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15776										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										15791									
Item #11, Film G406 11/20/68 km										CERTIFICATE OF DEATH																			
1. DECEASED-NAME (Type or print) First Middle Last Charles Lewis Hilbert Miller										2a. DATE OF DEATH Month Day Year Nov 10 1968										2b. HOUR 6:30 PM									
3. SEX Male					4. RACE White					5. DATE OF BIRTH 25 Sept 1897					6. AGE (In years last birthday) 71 YRS.					IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) Maryland					7b. CITIZEN OF WHAT COUNTRY? U.S.A.					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH Carroll Md.														
10. CITY OR TOWN OF DEATH Manchester					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 114 N. Main Street					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Butcher					12b. KIND OF BUSINESS OR INDUSTRY Butcher														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland					13b. COUNTY Carroll					13c. CITY OR TOWN Manchester					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER 114 N. Main St									
14. FATHER'S NAME First Middle Last William H Miller										15. MOTHER'S MAIDEN NAME First Middle Last Virginia Elizabeth Ann Rodding																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No					(If yes give war or dates of service)					16b. SOCIAL SECURITY NO. 219-20-2360					17. INFORMANT Address Mrs Mary Miller 114 N. Main St Manchester Md														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic Heart Disease</u> 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>generalized arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>5 yrs</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4200 <u>Cerebrovascular Insufficiency</u>																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from Dec 1948, to Nov 10, 1968, that (I) (we) lost saw the deceased alive on Nov 10 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE W H Foard M.D										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED 11-10-68									
22d. PHYSICIAN'S NAME (Type) W. H. Foard M.D					22e. ADDRESS Manchester, Md 21102																								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE Nov. 13, 1968					23c. NAME OF CEMETERY OR CREMATORY Immanuel Cemetery					23d. LOCATION (City or Town) (County) (State) Manchester Carroll Co. Md.														
24. FUNERAL DIRECTOR Tipton - Eline Funeral Home Hampstead, Md.										ADDRESS										25a. REC'D BY REGISTRAR DATE NOV 14 1968					25b. REGISTRAR'S SIGNATURE Charles Judge				







MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15777

15792

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenmount</u>		c. LENGTH OF STAY IN lb <u>25 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenmount, Rural</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>(Rural)</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Harry</u> First <u>Curtis</u> Middle <u>Miller</u> Last				4. DATE OF DEATH Month <u>Nov</u> Day <u>7</u> Year <u>1968</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 19, 1894</u> 74 yrs.	
9. AGE (In years last birthday) <u>74</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Co. Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Henry C Miller</u>				14. MOTHER'S MAIDEN NAME <u>Hennetta Talbert</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-24-954</u>		17. INFORMANT <u>Mrs Harry Miller</u> Address <u>Greenmount, Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>4109</u> IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> stating the underlying cause last. (c) <u>1 yr</u>						INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>4201</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>June</u> , 1955, to <u>Nov 7</u> , 1968, that (1) (we) last saw the deceased alive on <u>Oct 5</u> , 1968, and that death occurred at <u>10 P</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>W H Foard</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/7/68</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. H Foard M.D.</u>				22d. ADDRESS <u>MANCHESTER, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 11, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fairview Methodist Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Sunnybrook, Md.</u>	
24. FUNERAL DIRECTOR <u>Tipton - Eline Funeral Home Hampstead, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 13 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15222

COAST GUARD OF CANADA

15222



NOV 13 1968

THE CANADIAN COAST GUARD

NOV 13 1968

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be procured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15778												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												15793			
Items#13a,b,c,&e, FilmG406 11/21/CERTIFICATE OF DEATH																											
1. DECEASED-NAME (Type or print) <b>Augustus A. Myers</b>										2a. DATE OF DEATH Month <b>November</b> Day <b>14</b> Year <b>1968</b>										2b. HOUR <b>8 P M</b>							
3. SEX <b>Male</b>				4. RACE <b>White</b>				5. DATE OF BIRTH <b>10/19/1877</b>				6. AGE (In years last birthday) <b>91</b> YRS.				IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) <b>Carroll Co. Md.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH <b>Carroll</b> Md.															
10. CITY OR TOWN OF DEATH <b>Littlestown, Pa. R-2</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Mailing Address Littlestown, Pa. R-2</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired Farmer</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>															
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>				13b. COUNTY <b>Carroll</b>				13c. CITY OR TOWN <b>RD 2 Littlestown</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>RD. #2</b>													
14. FATHER'S NAME First Middle Last <b>Josephus Myers</b>										15. MOTHER'S MAIDEN NAME First Middle Last <b>Maria Myers</b>																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b>				16b. SOCIAL SECURITY NO. <b>204-40-2797</b>				17. INFORMANT Address <b>Mrs. William H. Snyder, Littlestown, Pa. R-2</b>																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4299</b> <i>Myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF <i>Decomposition</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Accompanied by pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF <i>3 day</i> (c) <i>6 hours</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 hours</i>																											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4222</b> <i>Semileth</i>																											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 2</b> , 19 <b>68</b> , to <b>Nov 14</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Nov 14</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																											
22b. SIGNATURE <b>Mark L. Redding MD</b>										DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <b>11/15/68</b>													
22d. PHYSICIAN'S NAME (Type) <b>MARK Redding MD</b>										22e. ADDRESS <b>Harwood, Pa.</b>																	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE <b>11/17/68</b>				23c. NAME OF CEMETERY OR CREMATORY <b>St. Marys Cemetery</b>				23d. LOCATION (City or Town) (County) (State) <b>Silver Run, Carroll Co., Md.</b>															
24. FUNERAL DIRECTOR <b>Richard A Little</b>										ADDRESS <b>Littlestown, Pa.</b>				25a. REC'D BY REGISTRAR <b>NOV 18 1968</b>				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>									

U. S. GOVERNMENT PRINTING OFFICE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) <b>GENEVA ELIZABETH OWENS</b>					2a. DATE OF DEATH <b>Nov 32 68</b>			2b. HOUR <b>7:35 P.M.</b>		
3. SEX <b>Female</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH <b>25 Oct 1899</b>		6. AGE (In years last birthday) <b>69</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL</b> Md.				
10. CITY OR TOWN OF DEATH <b>WESTMINSTER</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>34 Union St.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Domestic</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>CARROLL</b>		13c. CITY OR TOWN <b>WESTMINSTER</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER - <b>34 Union St.</b>	
14. FATHER'S NAME First <b>Fletcher</b> Middle <b>Tyler</b> Last <b>Susie Smith</b>			15. MOTHER'S MAIDEN NAME First <b>Susie Smith</b> Middle <b>-</b> Last <b>-</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>212-32-2511</b>		17. INFORMANT <b>Pepper Owens (Husband)</b> same Address <b>-</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASCVD.</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>-</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 19 <b>68</b> to <b>32 Nov</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>21 Nov 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Dean H. Griffin</b> DEGREE <b>-</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <b>22 Nov 68</b>				
22d. PHYSICIAN'S NAME (Type) <b>DEAN H. GRIFFIN</b>						22e. ADDRESS <b>19 Ridge Rd., Westminster Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>11/25/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GARDENS OF ETERNAL HOPE</b>			23d. LOCATION (City or Town) (County) (State) <b>FINKSBURG CARROLL MD.</b>		
24. FUNERAL DIRECTOR <b>J. E. Myers Jr., Westminster, Md.</b> ADDRESS <b>-</b>						25a. REC'D BY REGISTRAR <b>NOV 25 1968</b> DATE		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

RECEIVED BY DEAN

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Miss Smith

1914-1915

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University of Wisconsin

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
15780									
15795									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
John W. Plunkert						November 18 1968		11:30 P M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR	
Male		White		8/5/1904		64 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Adams County, Pa.		U.S.A.				Carroll			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Mailing Address		Mailing Address		Farming		Farm			
Littlestown, Pa. R.D. 1		Littlestown, Pa. R-1 Co. Md.							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Mailing Address	
Md.		Carroll						Littlestown, Pa. R-1.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
James - Plunkert			Martha - Rebert						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		207-30-7482		Mrs. Edna C. Plunkert, Littlestown, Pa. R-1		Carroll Co. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Chronic Atherosclerotic Cardio-Vascular Disease</u>								5 years	
4129 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) <u>Pulmonary Emphysema</u>								20 years	
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
4221 <u>Bronchial Asthma</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from FEB. 26, 1965, to NOV. 18, 1968, that (I) (we) last saw the deceased alive on NOV. 18, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		L. L. Potter M.D.		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
								NOV. 20, 1968	
22d. PHYSICIAN'S NAME (Type)		L. L. POTTER M.D.		22e. ADDRESS		LITTLESTOWN, PA.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		11/22/68		St. Marys Cemetery		Silver Run, Carroll Co., Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Richard A. Little		Littlestown, Pa.		NOV 21 1968		Charles Judge			

OFFICE OF THE SECRETARY

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# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15781

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15796

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) <b>NOAH BURNELL POWELL</b>			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> 11-23 1968			2b. HOUR ? M			
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH <b>MAY 27 1913</b>	6. AGE (In years last birthday) <b>55</b> YRS.	IF UNDER 1 YEAR MONTHS _____ DAYS _____	IF UNDER 24 HRS HOURS _____ MIN. _____	2c. DATE PRONOUNCED DEAD Month <b>11</b> Day <b>24</b> Year <b>1968</b>			
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL Co.</b>			
10. CITY OR TOWN OF DEATH <b>WESTMINSTER</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>203 1/2 COURT ST.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>CARPENTER ALSO BUTCHER</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>		13b. COUNTY <b>CARROLL</b>		13c. CITY OR TOWN <b>WESTMINSTER</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <b>203 1/2 COURT ST.</b>	
14. FATHER'S NAME First <b>MILTON J.</b> Middle <b>POWELL</b> Last <b>POWELL</b>			15. MOTHER'S MAIDEN NAME First <b>LUCY</b> Middle <b>KEMPER</b> Last <b>KEMPER</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>YES</b>			
16b. SOCIAL SECURITY NO. <b>217-07-3466</b>			17. INFORMANT <b>MRS RUSSELL C. DOBSON</b>			ADDRESS <b>E. MAIN ST MD WESTMINSTER</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastric Hemorrhage</b> <b>5310</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Possible Gastric Ulcer</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>HOURS</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <b>5400</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. _____ P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Charles J. Judge</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>11-24-68</b>			
EXAMINER'S NAME (Type) <b>Charles J. Judge</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>11/27/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PLEASANT VALLEY</b>		23d. LOCATION (City or Town) (County) <b>WESTMINSTER CARROLL MD</b>		
24. FUNERAL DIRECTOR <b>J.S. Myroff</b>			ADDRESS <b>Westminster, Md.</b>			25a. REC'D BY REGISTRAR <b>DEC 2 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in the space provided. 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15788

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15797

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) First Middle Last <b>LUCY VIOLA HOLDER PRATT</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year <b>11-16 1968</b>			2b. HOUR- M <b>5:15 A M</b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>7-16-1888</b>	6. AGE (In years last birthday) <b>80 YRS.</b>	IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>	IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>	2c. DATE PRONOUNCED DEAD Month Day Year <b>11 16 1968</b>	
7a. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b>	
10. CITY OR TOWN OF DEATH <b>Sevierville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield State Hosp. Sevierville</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Seamstress</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Sevier</b>		13c. CITY OR TOWN <b>Sevierville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>2105 Hillman Drive</b>		14. FATHER'S NAME First Middle Last <b>Peter Fisk Heaton</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Margaret Bauer</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>246-32-8641</b>		17. INFORMANT <b>Springfield State Hospital Records</b>		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF <b>with Congestive Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <b>4200</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Fracture of Hip &amp; Cerebral Arteriosclerosis</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year <b>11-7 1968</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Fell out of Chair</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (Home, School, Factory, Office, Building, etc.) <b>Springfield State Hospital</b>		21f. LOCATION Street or R.F.D. No. City or Town County State <b>Sevierville Carroll Md</b>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>W. Glenn Peicher</b>		EXAMINER'S NAME (Type) <b>W. Glenn Peicher</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Charles Westmeyer</b>		22b. DATE SIGNED <b>11-16-68</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>11/16/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Forsyth Memorial Park</b>		23d. LOCATION (City or Town) (County) <b>Winston-Salem, N. C.</b>	
24. FUNERAL DIRECTOR <b>The H. Lines Co.</b>				ADDRESS <b>2901 14th St. NW</b>		25a. REC'D BY REGISTRAR <b>NOV 19 1968</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



NAME: [illegible]  
DATE: [illegible]  
[illegible text follows, mostly illegible due to fading and bleed-through]



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15783

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15798

1. DECEASED-NAME (Type or Print) <b>EUNICE A. RENSHAW</b>			2a. DATE KNOWN OF DEATH Month <b>11</b> Day <b>13</b> Year <b>1968</b>			2b. HOUR <b>9:50</b> A.M.			
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>3-10-94</b>	6. AGE (In years last birthday) <b>74</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b>	IF UNDER 24 HRS. DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b>	IF UNDER 24 HRS. MIN <b>0</b>	2c. DATE PRONOUNCED DEAD Month <b>11</b> Day <b>13</b> Year <b>1968</b>	2d. HOUR <b>9:50</b> A.M.
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll County,</b> Md.			
10. CITY OR TOWN OF DEATH <b>Sykesville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield State Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>***</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Bethesda</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>Street address not listed</b>	
14. FATHER'S NAME First <b>Benjamin</b> Middle <b>Bean</b> Last <b>Bean</b>			15. MOTHER'S MAIDEN NAME First <b>Mary</b> Middle <b>Blondon</b> Last <b>Blondon</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>			16b. SOCIAL SECURITY NO. <b>220-54-6650</b>		17. INFORMANT ADDRESS <b>Records, Springfield State Hospital</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary embolism</b> <b>450X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>450X</b> (b) <b>Aneurysm of aorta</b> (c) <b>Myocardial infarct.</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) <b>465X Arteriosclerosis.</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>W. Glenn Speicher</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED <b>11-13-68</b>			
EXAMINER'S NAME (Type) <b>W. Glenn Speicher</b>			ADDRESS <b>1355 Main Street, Westminster, Carroll Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11-16-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cemetery</b>		23d. LOCATION (City or Town) (County) <b>Bethesda, Montg. Maryland</b>			
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland.</b>				25a. REC'D BY REGISTRAR <b>NOV 20 1968</b>		25b. REGISTRAR'S SIGNATURE <b>W. Glenn Speicher</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15784		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				15799	
1. DECEASED-NAME (Type or print) First Middle Last PAUL M. ROCHE						2a. DATE OF DEATH Month Day Year NOVEMBER 25 1968	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH JAN 22 1885		2b. HOUR 6:30 PM	
6. AGE (In years last birthday) 83 YRS.		7. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) CORK IRELAND		9. COUNTY OF DEATH CARROLL		10. CITY OR TOWN OF DEATH SYKESVILLE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) BOX 331 LIBERTY RD	
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) ARTIST		12b. KIND OF BUSINESS OR INDUSTRY PAINTING		13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13b. COUNTY CARROLL	
13c. CITY OR TOWN SYKESVILLE		13d. STREET AND NUMBER BOX 331 LIBERTY RD		13e. STATE MARYLAND		13f. COUNTY CARROLL	
14. FATHER'S NAME First Middle Last WILLIAM ROCHE		15. MOTHER'S MAIDEN NAME First Middle Last MARY O'DEA		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO. 214-03-2826A	
17. INFORMANT Address MARIE SQUIRES BOX 331 LIBERTY RD.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> 4272 DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARDIAC BLOCK &amp; PACEMAKER</u> 5 YRS. DUE TO, OR AS A CONSEQUENCE OF (c) <u>HEMIPARESIS &amp; CERV. VERT FRX</u> 2 YRS. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min.		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4330			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>JULY</u> , 19 <u>64</u> , to <u>11-25</u> , 19 <u>68</u> , that (I) (we) lost the deceased alive on <u>11-25</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>R. V. Houck, MD</u>		22c. DATE SIGNED 11-25-68		22d. PHYSICIAN NAME (Type) RV HOUCK JR		22e. ADDRESS LIBERTY RD ELDERSBURG. MD.	
23a. BURIAL, CREMATION, REBURY (Specify) BURIAL		23b. DATE NOV 27 1968		23c. NAME OF CEMETERY OR CREMATORY LAKE VIEW MEMORIAL		23d. LOCATION (City or Town) (County) (State) LIBERTY RD CARROLL MD	
24. FUNERAL DIRECTOR ADDRESS THE DIPPEL BROS INC 7110 BELAIR RD.		25a. REC'D BY REGISTRAR DATE NOV 27 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

RECORD OF DEATH

NAME	WHITE
AGE	25
SEX	M
DATE OF BIRTH	1900
DATE OF DEATH	1925
PLACE OF BIRTH	INDIANA
PLACE OF DEATH	INDIANA
Cause of Death	...
Signature	...
Witness	...
Registrar	...

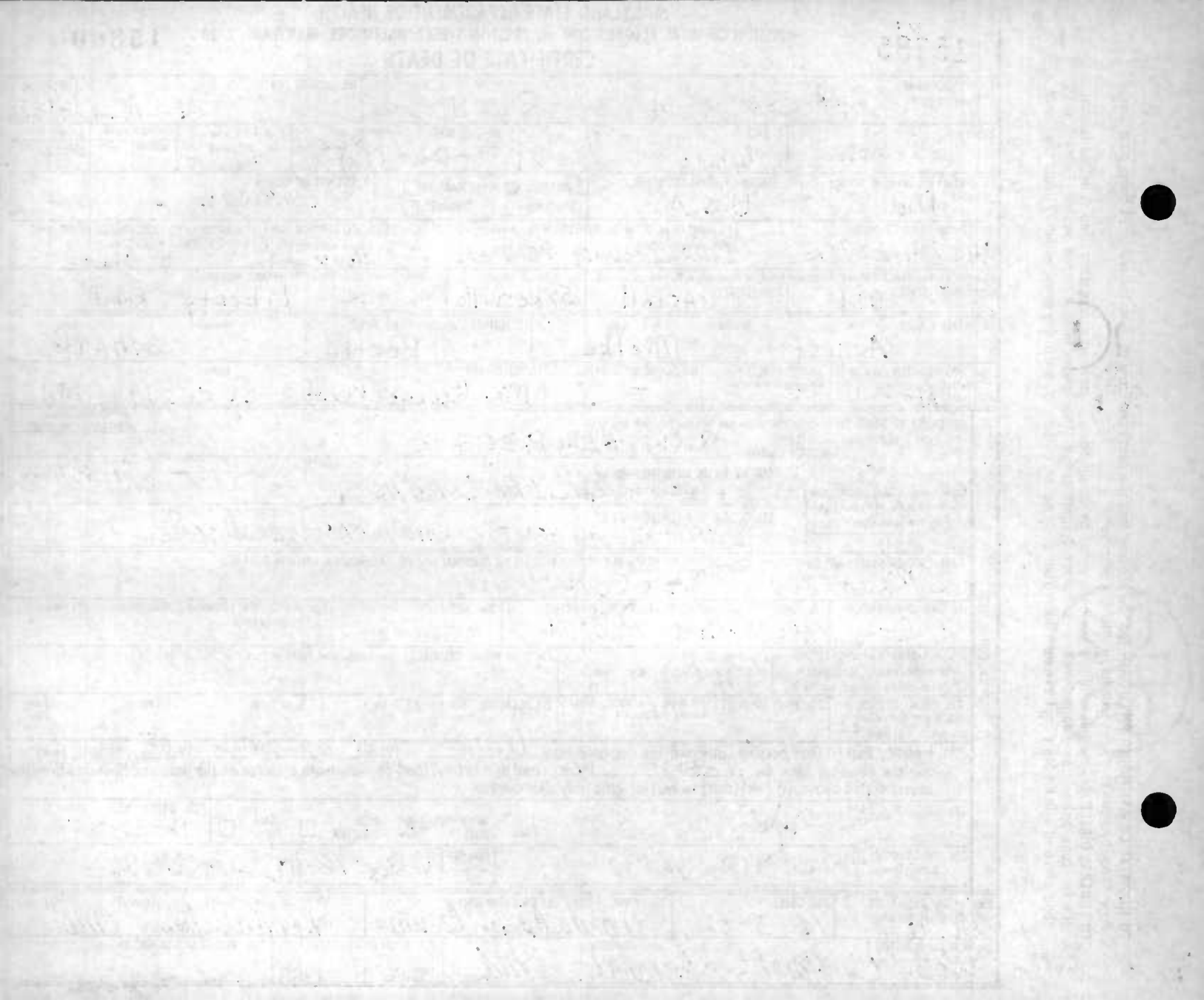
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 5 (4)  
30M REV 1-1-68

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH			2b. HOUR	
BERTHA		A.		RUCH	Month	Day	Year	4:40 PM	
3. SEX	Female		4. RACE	White		5. DATE OF BIRTH		6. AGE (In years last birthday)	
						7-22-1889		79 YRS.	
7a. BIRTHPLACE (State or foreign country)	Md.		7b. CITIZEN OF WHAT COUNTRY?	U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
								CARROLL	
10. CITY OR TOWN OF DEATH	WESTMINSTER		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	CARROLL COUNTY GENERAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
						Housewife		Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	Md		13b. COUNTY	CARROLL		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER	
								Liberty Road	
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
	August		Mielke			Bertha		Schalk	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)	No		16b. SOCIAL SECURITY NO.	-		17. INFORMANT		Address	
						MR. George Ruch		Sykesville Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4221 (b) Cerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Cardiovascular Disease								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 HRS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) CARCINOMA OF RECTUM									
19a. DATE OF OPERATION	11-19-68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		CARCINOMA OF RECTUM		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
	Hour A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County
									State
22a. I certify that (I) (this hospital) attended the deceased from 11-16-1968, to 11-30-1968, that (I) (we) last saw the deceased alive on 11-30-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE						DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED
									11-30-68
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
HANS NIPKOW						RFD 4, Box 418, WESTMINSTER, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)
Burial	12-3-68		Wards Chapel Cemetery		Randallstown		Md.		
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Harry W Haight Sykesville, Md.					DATE 12-3-1968		[Signature]		







FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15786

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15801

1. DECEASED-NAME (Type or Print)		First IRA	Middle McGee	Last SHANHOLTZ		20. DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year		2b. HOUR
						Nov. 9, 68		9:50 AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH 5/21/18		6. AGE (In years last birthday) 50? YRS.	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
7a. BIRTHPLACE (State or foreign country) W. Va		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll		Md.
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Carroll County Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) carpenter		12b. KIND OF BUSINESS OR INDUSTRY Building		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN YES <input type="checkbox"/> NO <input type="checkbox"/> RT. 1		13e. STREET AND NUMBER Frankburg Finksburg		
14. FATHER'S NAME Ira		First	Middle	Lost SHANHOLTZ		15. MOTHER'S MAIDEN NAME Lillian Albright		First Middle Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) WWII		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Doris SHANHOLTZ		ADDRESS Finksburg, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stab wound of Neck</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>966X</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>982X</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOURS MIN 9:15 P.M. Nov. 9, 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Stabbed by wife				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F.D. No. Rt. 1, Frankburg		City or Town Westminster		County Carroll
						State M.D.		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED November 10, 1968
EXAMINER'S NAME (Type)				ADDRESS (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 11/13/68	23c. NAME OF CEMETERY OR CREMATORY Island Hill		23d. LOCATION (City or Town) Paw Paw		(County) W. Va		(State)
24. FUNERAL DIRECTOR John R. Black		ADDRESS Elliot City, Md.		25a. REC'D BY REGISTRAR DATE NOV 13 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15787

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15802

1. DECEASED-NAME (Type or Print) <b>JOHN WILLIAM SHERFEY</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>11</b> Day <b>27</b> Year <b>1968</b>			2b. HOUR <b>7:15</b> P M	
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH <b>MAY 21-1888</b>	6. AGE (In years last birthday) <b>80</b> YRS.	IF UNDER 1 YEAR MONTHS <b>1</b> DAYS <b>27</b>	IF UNDER 24 HRS. HOURS <b>7</b> MIN. <b>15</b>	2c. DATE PRONOUNCED DEAD Month <b>11</b> Day <b>27</b> Year <b>1968</b>	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL</b>	
10. CITY OR TOWN OF DEATH <b>WESTMINSTER</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>1 HERSH AVE</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>CARPENTER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>WOOD</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>CARROLL</b>		13c. CITY OR TOWN <b>WESTMINSTER</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
14. FATHER'S NAME First <b>SAMUEL</b> Middle <b>D</b> Last <b>SHERFEY</b>		15. MOTHER'S MAIDEN NAME First <b>AMANDA</b> Middle <b>KUMP</b> Last <b>KUMP</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>216-03-5848</b>		17. INFORMANT <b>WILBUR SHERFEY</b>		ADDRESS <b>WESTMINSTER MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerosis (heart)</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Sudden</b> <b>Severe</b> <b>Yes</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b>							
19a. DATE OF OPERATION <b>May-1968</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>Ca Lt Side Face</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>19</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>W Glenn Speicher</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>11-27-68</b>	
EXAMINER'S NAME (Type) <b>W GLENN SPEICHER</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) <b>135 S Main Westminister Carroll</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>12/1/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT HOPE</b>		23d. LOCATION (City or Town) (County) <b>WOODSBORO MD</b>	
24. FUNERAL DIRECTOR <b>DD Hartzler Sons New Windsor</b>				ADDRESS <b>New Windsor</b>		25a. REC'D BY REGISTRAR <b>DEC 2 1968</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

15882

RECEIVED

1968

DEC 8 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last Dean (NMN) Shillito						2a. DATE OF DEATH Month Day Year 11 22 68			2b. HOUR 9:15 AM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH 5-27-91		6. AGE (In years last birthday) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.					
10. CITY OR TOWN OF DEATH Sykesville			11. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital give street address) Springfield State Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Washington Co.		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 129 Harp Road		
14. FATHER'S NAME First Middle Last Edward Shillito				15. MOTHER'S MAIDEN NAME First Middle Last Ida Leshner							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None			16b. SOCIAL SECURITY NO. 220-16-3383		17. INFORMANT Address Hospital records						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Acute Congestive heart failure</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(b) <u>Arteriosclerotic heart disease</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY -- HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) --					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) --			21f. LOCATION Street or R.F.D. No. City or Town County State			--		
22a. I certify that <del>the</del> (this hospital) attended the deceased from <u>April 5, 1966</u> , to <u>November 22, 1968</u> , that <del>it</del> (we) last saw the deceased alive on <u>November 22, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <del>it</del> (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Balbir Singh, M.D.</u>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED 11/22/68		
22d. PHYSICIAN'S NAME (Type) Balbir Singh, M.D.						22e. ADDRESS Springfield State Hospital, Sykesville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/25/1968		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			23d. LOCATION (City or Town) (County) (State) Greencastle, Franklin Pa.				
24. FUNERAL DIRECTOR <u>Howard M. Zimmerman</u>						25b. REC'D BY REGISTRAR DATE <u>NOV 25 1968</u>			25a. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

10861

RECORD OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 1 Film 410 3/4/69 kk

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15789

15804

# CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <u>a/k/a</u> First <u>Florence</u> Middle <u>Melson</u> Last <u>Simpkins</u>		2a. DATE OF DEATH Month <u>Nov.</u> Day <u>17</u> Year <u>1968</u>		2b. HOUR M
3. SEX <u>Female</u>	4. RACE <u>White</u>	5. DATE OF BIRTH <u>Nov. 9 1892</u>	6. AGE (In years lost birthday) <u>86</u> YRS.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <u>md.</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <u>Carroll</u>	
10. CITY OR TOWN OF DEATH <u>Sykesville</u>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Pine Knob Rd.</u>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Seamstress</u>	12b. KIND OF BUSINESS OR INDUSTRY <u>Sewing</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>md.</u>	13b. COUNTY <u>Carroll</u>	13c. CITY OR TOWN <u>Sykesville</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <u>Pine Knob Rd.</u>
14. FATHER'S NAME First <u>Joseph</u> Middle <u>Melton</u> Last <u>—</u>	15. MOTHER'S MAIDEN NAME First <u>Hester</u> Middle <u>—</u> Last <u>Unk.</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <u>No</u>	16b. SOCIAL SECURITY NO. <u>213 05 6324</u>	17. INFORMANT Address <u>Mr. Stephen Simpkins Sykesville Md.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASHD, Arrhythmia fibrillation, Arteriosclerosis</u> <u>4129</u> DUE TO, OR AS A CONSEQUENCE OF <u>generalized, Bronchial pneumonia,</u> <u>Post operative fractured hip.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7/29/68</u> <u>11/17/68</u>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>4200</u>				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>7/29/68</u> , 19 <u>68</u> , to <u>11/17</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11/17/68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <u>Howard E. Hall</u> M.D.		22c. DATE SIGNED <u>11/18/68</u>	22d. PHYSICIAN'S NAME (Type) <u>Dr. Howard E. Hall</u>	
22e. ADDRESS <u>College Ave. Sykesville, Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-20-68</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR <u>Harry W. Haight</u>	25a. REC'D BY REGISTRAR <u>Sykesville, Md.</u>	25b. REGISTRAR'S SIGNATURE <u>Phyllis Under</u>	DATE <u>NOV 21 1968</u>	

10804

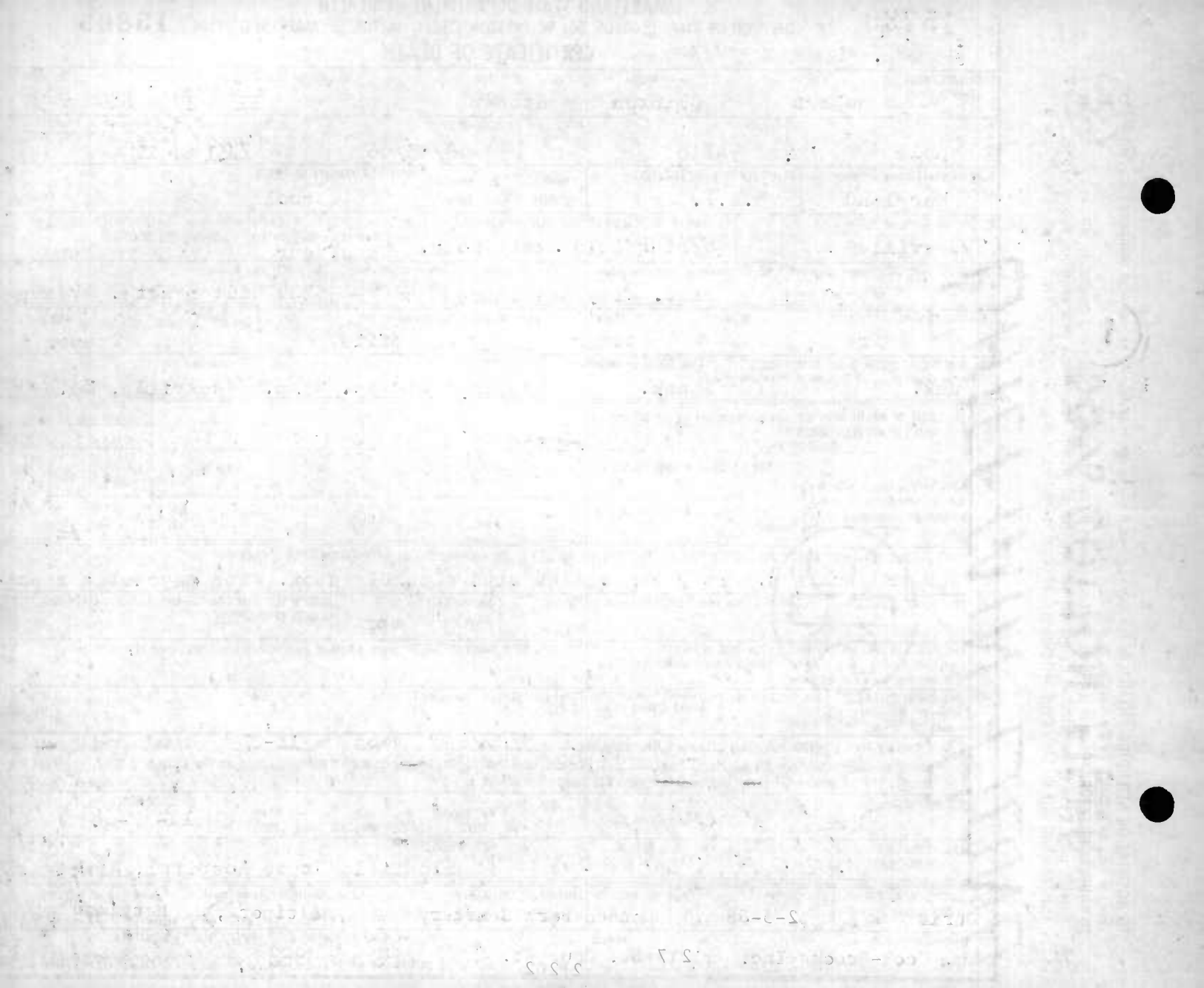
GRANITE OF MATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15790										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										15805									
Items#6, Film#407 12/9/68 km										CERTIFICATE OF DEATH																			
1. DECEASED-NAME (Type or print)					First Middle Last					2a. DATE OF DEATH					2b. HOUR														
Robert					Clinton					Stoner					Month Day Year					11 27 68					11 40 A. M.				
3. SEX					4. RACE					5. DATE OF BIRTH					6. AGE (In years last birthday)					IF UNDER 1 YEAR					IF UNDER 24 HRS.				
Male					White					12/13/06					62 1/2 YRS.					MONTHS DAYS					HOURS MIN.				
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH														
Maryland					U.S.A.										Carroll					Md.									
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY														
Sykesville					Springfield State Hosp.					Chauffeur																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS?					13e. STREET AND NUMBER									
Maryland					Balt. City					Baltimore					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					5204 Wilton Hgts. Avenue									
14. FATHER'S NAME					First Middle Last					15. MOTHER'S MAIDEN NAME					First Middle Last														
I					Ira Stoner					Effie					Trader														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16b. SOCIAL SECURITY NO.					17. INFORMANT					Address														
unk.					unk.					Springfield St. Hosp. Sykesville, Md.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 1. DEATH WAS CAUSED BY:																													
IMMEDIATE CAUSE (a) <u>Carcinoma of the Lung.</u>																													
1621 DUE TO, OR AS A CONSEQUENCE OF																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>163X</u>																													
(b) DUE TO, OR AS A CONSEQUENCE OF																													
(c)																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
Chronic brain syndrome associated with alcohol intox. with psychotic react.																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
					HOUR A.M. Month Day Year P.M. 19																								
21d. INJURY OCCURRED					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION																			
While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from <u>5/22/63</u> , 19 <u>63</u> , to <u>11-27</u> , 19 <u>68</u> , that (I) ( <del>was</del> ) last saw the deceased alive on <u>11-27</u> , 19 <u>68</u> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>was</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.																													
22b. SIGNATURE															DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED				
<u>Mario E. Comas</u>															MD										11-27-68				
22d. PHYSICIAN'S NAME (Type)															22e. ADDRESS														
MARIO E. COMAS															Springfield State Hospital, Sykesville														
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
Burial					12-5-68					Loudon Park Cemetery					Baltimore, Maryland														
24. FUNERAL DIRECTOR															ADDRESS					25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE				
Wm. Cook-Brooks Inc.															1217 St. Paul St.					DEC 5 1968					<u>Charles Judge</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please have carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR 4 A. M.	
George				Strauss	Nov.	24	68		
3. SEX Male	4. RACE White		5. DATE OF BIRTH Nov. 21, 1908		6. AGE (In years last birthday) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (State or foreign country) Balto. City		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.			
10. CITY OR TOWN OF DEATH Finksburg		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Green Mill Road		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Partner Western Auto Store		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Carroll		13c. CITY OR TOWN Finksburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Green Mill Road	
14. FATHER'S NAME George		First Middle Last George Strauss		15. MOTHER'S MAIDEN NAME Anna Dearcua		First Middle Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 217-07-2825		17. INFORMANT Mrs. Patricia K. Strauss			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture of aneurysm abdominal aorta</u> 441.2 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic--Hypertensive C.V. disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>457x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 minutes							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Cerebral thrombosis with left hemiplegia--5 months</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>September, 1962</u> , to <u>November, 1968</u> , that (I) <u>not</u> saw the deceased alive on <u>November 4, 1968</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> (did) <u>did not</u> view the body after death.									
22b. SIGNATURE <u>Martin E. Strobel, M.D.</u>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED November 24, 1968			
22d. PHYSICIAN'S NAME (Type) Martin E. Strobel, M. D.		22e. ADDRESS 59 Hanover Road, Reisterstown, Md. 21136							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Nov. 27, 68		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR J. F. Eline & Sons Reisterstown, Md.				ADDRESS		25a. REC'D BY REGISTRAR DATE NOV 27 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TESTIMONY OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 151  
30M REV. 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
15792									
15807									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last Josephine (NMN) Warfield TATE					2a. OATE OF DEATH Month Day Year November 13, 1968		2b. HOUR 3:30A		
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH 3-9-97		6. AGE (In years last birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll County, Md.			
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Nurse		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Balto. City		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 426 Hutchins Avenue	
14. FATHER'S NAME First Middle Last Richard Warfield				15. MOTHER'S MAIDEN NAME First Middle Last Emily unk.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. 216-09-3017B		17. INFORMANT Address Records, Springfield State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular disease</u> 4120 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pulmonary embolism</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 443X									
19a. OATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>6-5-1968</u> , to <u>11-13-1968</u> , that (I) (we) last saw the deceased alive on <u>11-13-1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dr. Antonius Glahn				DEGREE M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. OATE SIGNED 11-13-68	
22d. PHYSICIAN'S NAME (Type) Antonius Glahn, M.D.				22e. ADDRESS Springfield State Hospital					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/16/68		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn		23d. LOCATION (City or Town) (County) (State) Balto. Md.			
24. FUNERAL DIRECTOR Wm. L. Blatman Jr. - 1701 McCulloch St. Balto. Md.				ADDRESS		25a. RECEIVED BY REGISTRAR NOV 18 1968		25b. REGISTRAR'S SIGNATURE	

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Items 19a, 19b, 21b Film 407 11-27-68ams										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										15808	
15793										CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last JAMES (NMN) TELLEM					2a. DATE OF DEATH Month Day Year NOVEMBER 7, 1968					2b. HOUR 7:20 PM											
3. SEX Male			4. RACE White			5. DATE OF BIRTH 5-7-1892			6. AGE (In years last birthday) 76 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.							
7a. BIRTHPLACE (State or foreign country) Greece			7b. CITIZEN OF WHAT COUNTRY? Greece			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Carroll Md.												
10. CITY OR TOWN OF DEATH Sykesville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Restaurant Worker			12b. KIND OF BUSINESS OR INDUSTRY												
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Washington			13c. CITY OR TOWN Hagerstown			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER St. No. unknown Maryland Hotel									
14. FATHER'S NAME First Middle Last Nicholas Tellem					15. MOTHER'S MAIDEN NAME First Middle Last Unknown																
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 220-18-1774A			17. INFORMANT Address Records, Springfield State Hospital															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia, due to</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>053.4</u> (b) <u>Postoperative infection</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH weeks											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Schizophrenic reaction, paranoid type																					
19a. DATE OF OPERATION Sept 20/68			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Fracture prosthesis inserted for transcervical (R) femur			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?												
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) 7:55 PM Sept 18 1968			21b. TIME OF INJURY Hour A.M. Month Day Year 7:55 PM Sept 18 1968			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)															
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State															
22a. I certify that (I) (this hospital) attended the deceased from <u>6-30-56</u> , 19____, to <u>11-7-68</u> , 19____, that (I) (we) last saw the deceased alive on <u>11-7-68</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																					
22b. SIGNATURE Robert J. Dager										DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED 11-7-68								
22d. PHYSICIAN'S NAME (Type) Glocrito G. Sagisi, M. D.					22e. ADDRESS Springfield State Hospital Sykesville, Maryland 21784																
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 11-13-68		23c. NAME OF CEMETERY OR CREMATORY Freedom Cemetery			23d. LOCATION (City or Town) (County) (State) Sykesville Md.													
24. FUNERAL DIRECTOR Harry W. Haight					ADDRESS Sykesville, Md.					24a. REC'D BY REGISTRAR DATE NOV 18 1968			25b. REGISTRAR'S SIGNATURE Charles Judge								

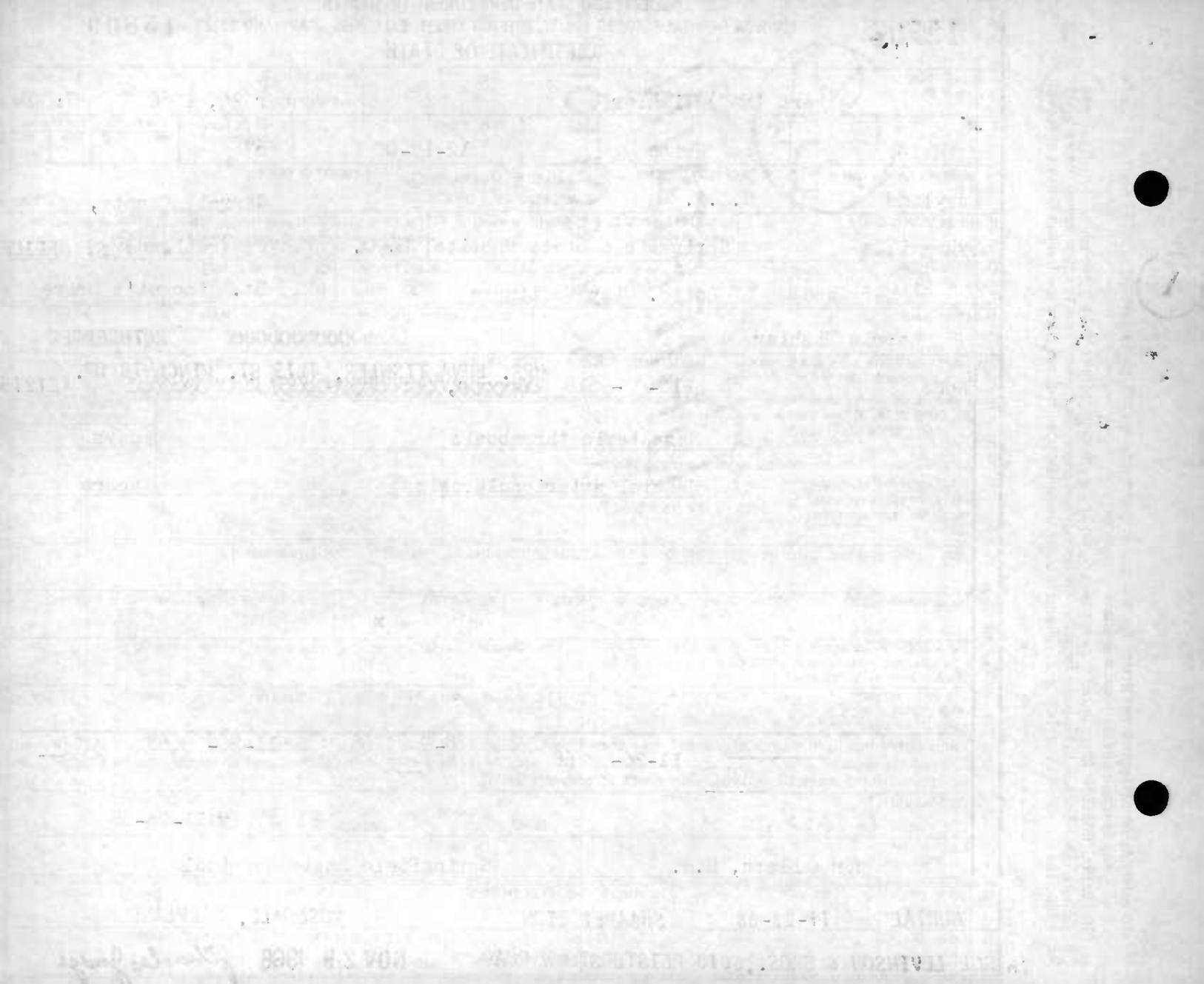


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

15794												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 15809													
1. DECEASED-NAME (Type or print) First Middle Last Albert (NMN) Tishler												2a. DATE OF DEATH Month Day Year November 26, 1968												2b. HOUR 7:30AM	
3. SEX Male				4. RACE White				5. DATE OF BIRTH 12-19-00				6. AGE (In years last birthday) 67 YRS.				IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.							
7a. BIRTHPLACE (State or foreign country) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Carroll County, Md.													
10. CITY OR TOWN OF DEATH Sykesville				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) XXXX employee (retired)				12b. KIND OF BUSINESS OR INDUSTRY POST OFFICE													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Balto. City				13c. CITY OR TOWN Baltimore				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4215 St. Vincent's Drive											
14. FATHER'S NAME First Middle Last Morris Tishler						15. MOTHER'S MAIDEN NAME First Middle Last Lena ROTHBERGER																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) None				16b. SOCIAL SECURITY NO. 216-01-5618				17. INFORMANT MRS. EDNA TISHLER, 4215 ST. VINCENTS DR. Address Secord, Carroll County, Md. #21215																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mesenteric thrombosis 4409 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 4500																									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State																	
22a. I certify that (I) (this hospital) attended the deceased from 8-9, 19-68, to 11-26, 19-68, that (I) (we) last saw the deceased alive on 11-26-19-68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																									
22b. SIGNATURE R. Llera														DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22c. DATE SIGNED 11-26-68							
22d. PHYSICIAN'S NAME (Type) Rena Llera, M.D.														22e. ADDRESS Springfield State Hospital											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE 11-27-68				23c. NAME OF CEMETERY OR CREMATORY SHAAREI ZION				23d. LOCATION (City or Town) (County) (State) ROSDALE, MARYLAND													
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD														25a. REC'D BY REGISTRAR DATE NOV 29 1968				25b. REGISTRAR'S SIGNATURE J. Charles Judge							





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VR 115 (4)  
30M REV. 48

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
15795												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) First Middle Last JAMES MORTIMER TOWNSEND						2a. DATE OF DEATH Month Day Year 11 28 68			2b. HOUR P 2:00 M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH 06/02/94			6. AGE (In years last birthday) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL Md.						
10. CITY OR TOWN OF DEATH Sykesville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Electrician			12b. KIND OF BUSINESS OR INDUSTRY Foreman			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Brookeville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME First Middle Last James L Townsend				15. MOTHER'S MAIDEN NAME First Middle Last Mary Hickrotte								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) no				16b. SOCIAL SECURITY NO. 577-09-3343		17. INFORMANT Hospital Records Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration pneumonia</u> <u>4129</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4200</u> (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hrs yrs		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) <u>with psychotic reaction</u> <u>Chronic Brain Syndrome assoc. with other diseases of unknown or uncertain cause/</u>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (X) (this hospital) attended the deceased from <u>Oct. 25, 1956</u> , to <u>Nov. 28, 1968</u> , that (X) (we) last saw the deceased alive on <u>Nov. 28, 1968</u> , and that in (a) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Suha Ozgun.</u>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>11/28/68</u>				
22d. PHYSICIAN'S NAME (Type) <u>Suha Ozgun, M. D.</u>						22e. ADDRESS <u>Springfield State Hosp., Sykesv., Md.</u>						
23a. BURIAL, CREMATION, REINTERMENT (Specify)		23b. DATE <u>Dec. 2, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel</u>		23d. LOCATION (City or Town) (County) (State) <u>Sunshine, Mont. Md.</u>						
24. FUNERAL DIRECTOR <u>Francis H. Barber</u>						ADDRESS <u>Laytonsville, Md.</u>		25a. REC'D BY REGISTRAR <u>DEC 4 1968</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

CERTIFICATE OF DEATH

1913

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

OCCUPATION

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

AGE AT BIRTH

SEX

OCCUPATION

EDUCATION

RELIGION

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

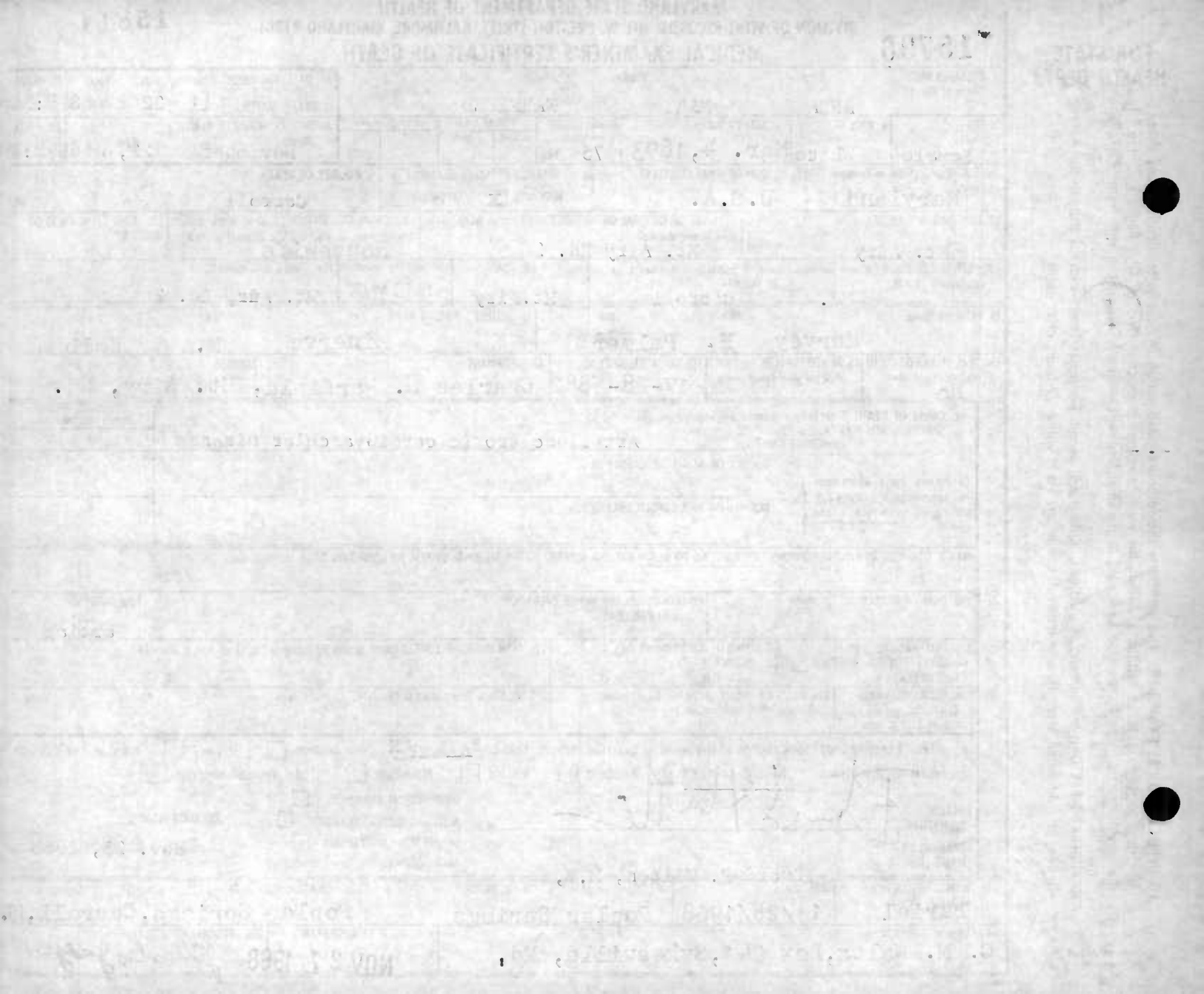
15796

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15811

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year			2b. HOUR		
ANNA MARY WARFIELD						11 22 1968			9:30p		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year			2d. HOUR
Female	White	Mar. 4, 1893	75 YRS.					November 22, 1968			9:20
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.		
Maryland		U.S.A.				Carroll					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Mt. Airy			Mt. Airy Rd. 2			Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md.				Carroll		Mt. Airy		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Mt. Airy Rd. 2	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
Harvey H. Palmer			Minerva M. Kolb								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS					
No			217-28-5882			Charles W. Warfield, Mt. Airy, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
4221											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> Partial <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held on <u>P</u> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type)			EDWARD F. WILSON, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)			22b. DATE SIGNED Nov. 23, 1968		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			11/25/1968			Poplar Springs			Poplar Springs, Carroll, Md.		
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
C. M. Waltz, Box 241, Sykesville, Md.						DATE NOV 27 1968			Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

15812

15797

1. DECEASED-NAME (Type or print) <b>Edward C. Wilhelm</b>			2a. DATE OF DEATH <b>Nov. 27 1968</b> Year			2b. HOUR <b>10 A</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Sept. 23, 1896</b>		6. AGE (In years last birthday) <b>72</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>Pa.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b> Md.				
10. CITY OR TOWN OF DEATH <b>Hampstead</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Rd 1</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Farmer</b>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Hampstead</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Rd 1</b>	
14. FATHER'S NAME First <b>Howard</b> Middle <b>E.</b> Last <b>Wilhelm</b>			15. MOTHER'S MAIDEN NAME First <b>Alice</b> Middle <b>Sterner</b> Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (unknown) <b>NO</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>217-07-6933</b>		17. INFORMANT Address <b>Addie Wilhelm Rd. 1 Hampstead</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of Prostate, Bone, Lungs</b> <b>185X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of Prostate</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 yrs</b> <b>Unknown</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>177X</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct. 1966</b> , to <b>Nov. 27 1968</b> , that (I) (we) last saw the deceased alive on <b>Nov. 27 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>M.C. Porterfield</b>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>11-27-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>M.C. Porterfield, M.D.</b>					22e. ADDRESS <b>Hampstead, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Nov. 30, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Shiloh Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Hampstead Md.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Tipton - Eline Funeral Home Hampstead, Md.</b>					25a. REC'D BY REGISTRAR <b>DEC 2 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

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UNITED STATES DEPARTMENT OF AGRICULTURE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15798

15813

1. DECEASED-NAME (Type or print) <i>Charlotte Kathryn Williams</i>			2a. DATE OF DEATH Month <i>11</i> Day <i>23</i> Year <i>68</i>			2b. HOUR <i>3:30</i> M.					
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>11-1-05</i>		6. AGE (In years last birthday) <i>63</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Illinois</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Carroll</i> Md.					
10. CITY OR TOWN OF DEATH <i>Sykesville, Md.</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Springfield State</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>City</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>301 McMechen Street</i>		
14. FATHER'S NAME First <i>Ozio</i> Middle <i>Lockwood</i> Last <i>Depper</i>			15. MOTHER'S MAIDEN NAME First <i>Catherine</i> Middle <i>Depper</i> Last <i>Depper</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or (unknown) <input type="checkbox"/>			16b. SOCIAL SECURITY NO. <i>241-74-7894</i>			17. INFORMANT <i>Records</i> Address <i>Springfield State Hospital, Sykesville, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart failure.</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Mitral rheumatic heart disease.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3940</i> weeks <i></i> years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>410X</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION - Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>10-23-</i> <i>1968</i> , to <i>11-23</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>11-23-</i> <i>1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Paul G. Ensor, M.D.</i>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>11/23/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>Paul G. Ensor, M.D.</i>						22e. ADDRESS <i>Springfield State Hospital Sykesville, Md. 21784</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE <i>11/25/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Greenmount Crematory</i>			23d. LOCATION (City or Town) (County) (State) <i>Balto. Md.</i>				
24. FUNERAL DIRECTOR <i>Mitchell-Wiedefeld Home 6500 York Rd. #21212</i>						25a. REC'D BY REGISTRAR DATE <i>Nov 26 1968</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last <b>Joanna E. Wisner</b>			2a. DATE OF DEATH Month Day Year <b>11 26 68</b>			2b. HOUR <b>11 P</b> M			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Aug. 7, 1948</b>		6. AGE (In years last birthday) <b>20</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b> Md.			
10. CITY OR TOWN OF DEATH <b>Westminster</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Carroll CO. Hospt.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Not Employed</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Manchester</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>15 N. Main St.</b>	
14. FATHER'S NAME First Middle Last <b>Charles M. Wisner</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Madaline Krebs</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b>		16b. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Charles Wisner Manchester, Md. (Father)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral Pneumonia</b> <b>324X</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Mental Retardation - Severe, and Quasidyslexia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Menigitis, Brain Abscess &amp; Septicemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>20 years</b> <b>20 yrs</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>352X</b> <b>Stress</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (the hospital) attended the deceased from <b>11-25</b> , 19 <b>68</b> , to <b>11-26</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>11-26</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Karen M. Freeman</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>11/26/68</b>			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
23a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>		23b. DATE <b>Nov. 29, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Jacob's Church Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Bordbecks, Pa.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Tipton - Eline Funeral Home Hampstead, Md.</b>				25a. REC'D BY REGISTRAR <b>DEC 2 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15815									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
15800									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last William Henry Zimmerman					2a. DATE OF DEATH 11 Month 15 Day 68 Year			2b. HOUR 6:30 a.m.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 11-17-1897		6. AGE (In years last birthday) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.			
10. CITY OR TOWN OF DEATH Rural--Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not hospital give street address) Springfield State		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) retired		12b. KIND OF BUSINESS OR INDUSTRY Laundry			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY Howard		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 925 Lyon Avenue	
14. FATHER'S NAME First Middle Last William H. Zimmerman					15. MOTHER'S MAIDEN NAME First Middle Last Ruth Souders				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) no		16b. SOCIAL SECURITY NO. 577-16-1760A		17. INFORMANT Address Springfield Hospital record, Sykesville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic come, due to</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cirrhosis of liver</u> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 581.0									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 9-4-1968, to 11-15-1968, that (I) (we) lost the deceased on 11-15-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I), (we) (did) (did not) view the body after death.									
22b. SIGNATURE Octavio Ruiz M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 11-15-68		
22d. PHYSICIAN'S NAME (Type) Octavio Ruiz, M.D.					22e. ADDRESS Springfield State Hospital Sykesville, Maryland 21784				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Nov 18, 1968		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.			
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.					25a. REC'D BY REGISTRAR DATE NOV 18 1968		25b. REGISTRAR'S SIGNATURE Charles Jones		



*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "THE", "AND", "OF" are visible.]*

